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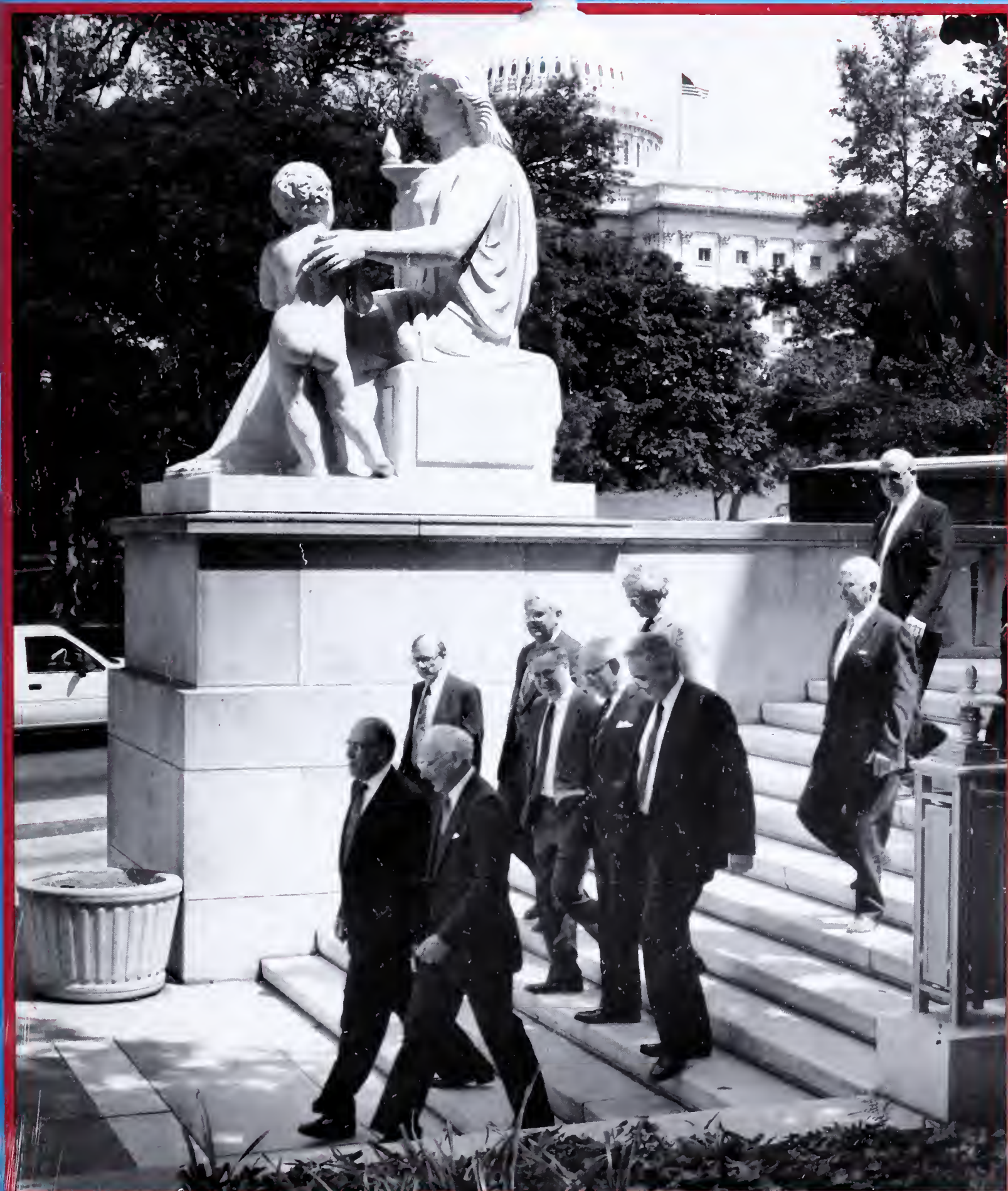
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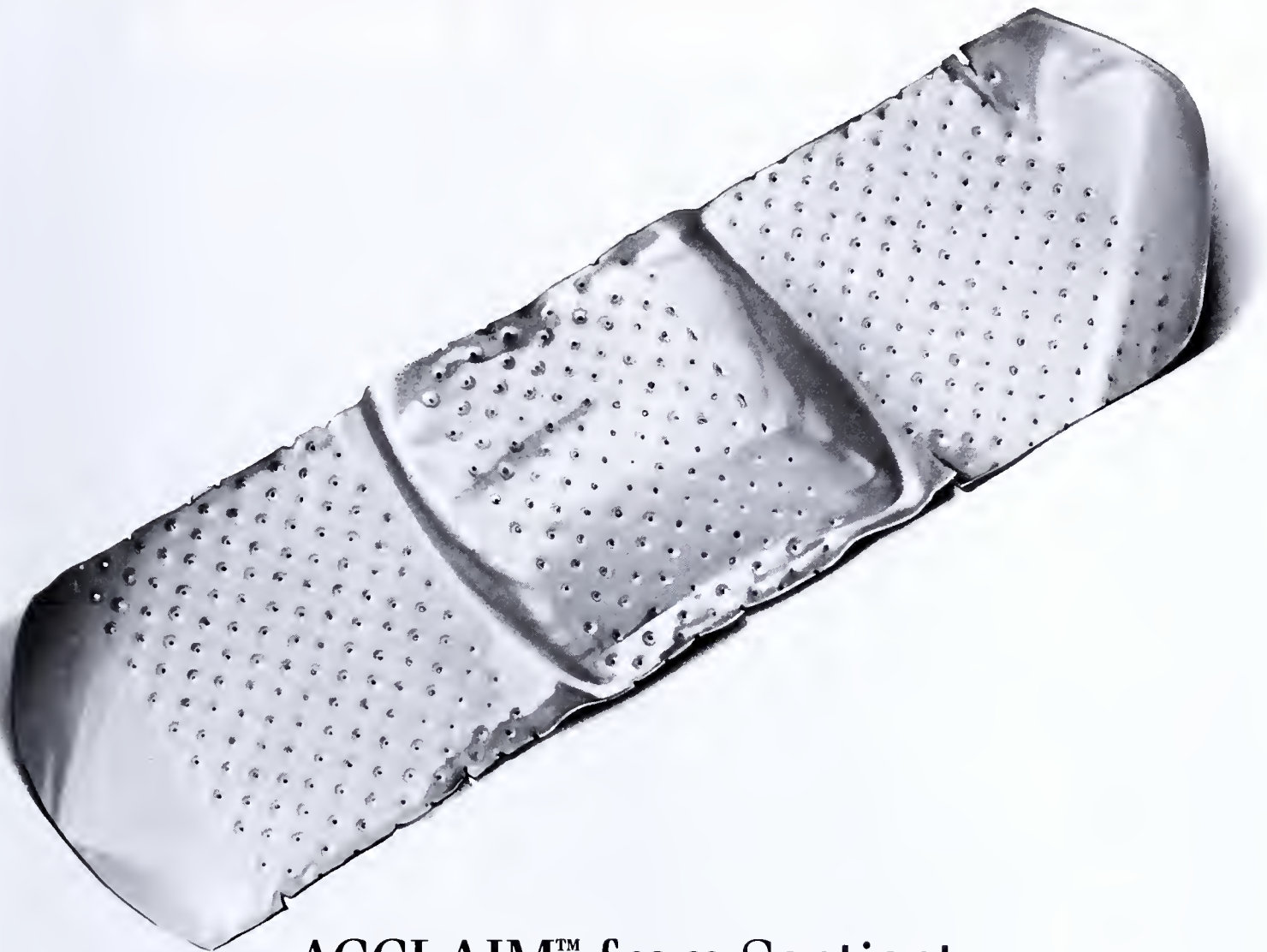
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### Table of Contents

Summer (July/August/September) 1991 / Volume 118 / Number 3

#### ON THE COVER

---

Headed for the entrance to the Rayburn Building in Washington are these Medical Society of Virginia officers and councilors: Richard L. Fields, Palmer W. Fant, Ira D. Godwin, Kenneth D. Tuck, Edwin J. Harvie, Jr., Bennie Seal, Charles M. Caravati, Jr., George B. Craddock, Jr., Raymond S. Brown, and Louis D. Parham, Jr. Looming above them is "Spirit of Justice," sculpted by Paul Jennewein for the Rayburn Building when it was built in 1965.

- 142 **31st Reprise of a Trip to the Hill** Notes and photographs from the 1991 Congressional Luncheon and briefings.
- 146 **To statesmen in a quandary: "Face the voters and tell it like it is."**  
JOHN A. OWEN, JR.

#### MEDICINE

---

- 159 **Post-Acute Management of Head Injuries**  
HENRY H. STONNINGTON
- 166 **First Single Lung Transplant in Virginia**  
C.G. TRIBBLE, J.A. KERN, L.J. FINDLEY, T.M. DANIEL, J.D. TRUWIT,  
C.E. ROSE, JR., B.F. LEWIS, and I.L. KRON
- 169 **Use of Azathioprine in Nine Children with Crohn's Disease**  
MAHENDRA D. SHAH and WALLACE F. BERMAN
- 171 **Alcohol Abuse Among College Freshmen in Greek Societies**  
R.J. CANTERBURY, C.F. GRESSARD, W.V.R. VIEWEG, S.J. GROSSMAN,  
R.B. MCKELWAY, and P.S. WESTERMAN
- 173 **Role of Colonoscopy in Treatment of Colorectal Carcinoma**  
LUIZ E. G. MINEIRO
- 175 **Abstracts from the Virginia Society of Otolaryngology/Head and Neck Surgery**

#### MEDICAL RECORDS

---

- 179 **Broader Surrogate Scope Affects Old, New Living Will Declarations** Coupon for ordering forms and physician's guidelines.

*continued over*

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## Contents continued

### COMMUNICATING

- 168 **Listening** JACK C. TURNER  
168 **Touching** DAVID A. ZOHN

### BOOKS

- 157 **Medical Landmarks USA**, by Martin B. Lipp  
Reviewed by BARRY V. KIRKPATRICK

### EDITORIALS

- 180 **More About Health Care**  
180 **Want to Practice Medicine?**  
181 **All for One**  
E.L. KENDIG, JR.  
180 **Both of Us**  
H.S. CAMPELL

### OBITUARY

- 183 **Deaths of MSV Members**  
183 **Memoir of Leslie Bond** GIRARD V. THOMPSON, SR.  
184 **Memoir of Leslie Rudolf** JOHN B. HANKS  
184 **Memoir of Porter Echols** WILLIAM H. BARNEY  
185 **Memoir of Tom Bithell** CHARLES E. HESS  
185 **Memoir of A.D. Crosett**  
ROBERT J. NEWMAN and ROBERT E. HOYT

### DEPARTMENTS

- 139 **Letters to the Editor**  
JOHN W. PAINTER, F.J. SPENCER,  
WILLIAM D. RUSHER, and JOHN M. DANIEL III  
140 **Medical Society of Virginia Officers**  
153 **Meetings about Medicine**  
191 **New MSV Members**  
194 **Classified Advertisements**  
198 **Who's Who**





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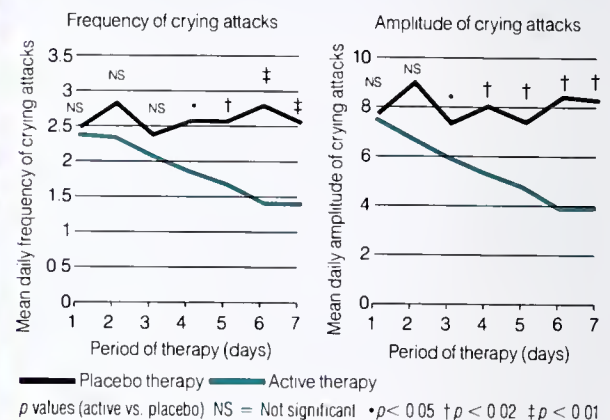
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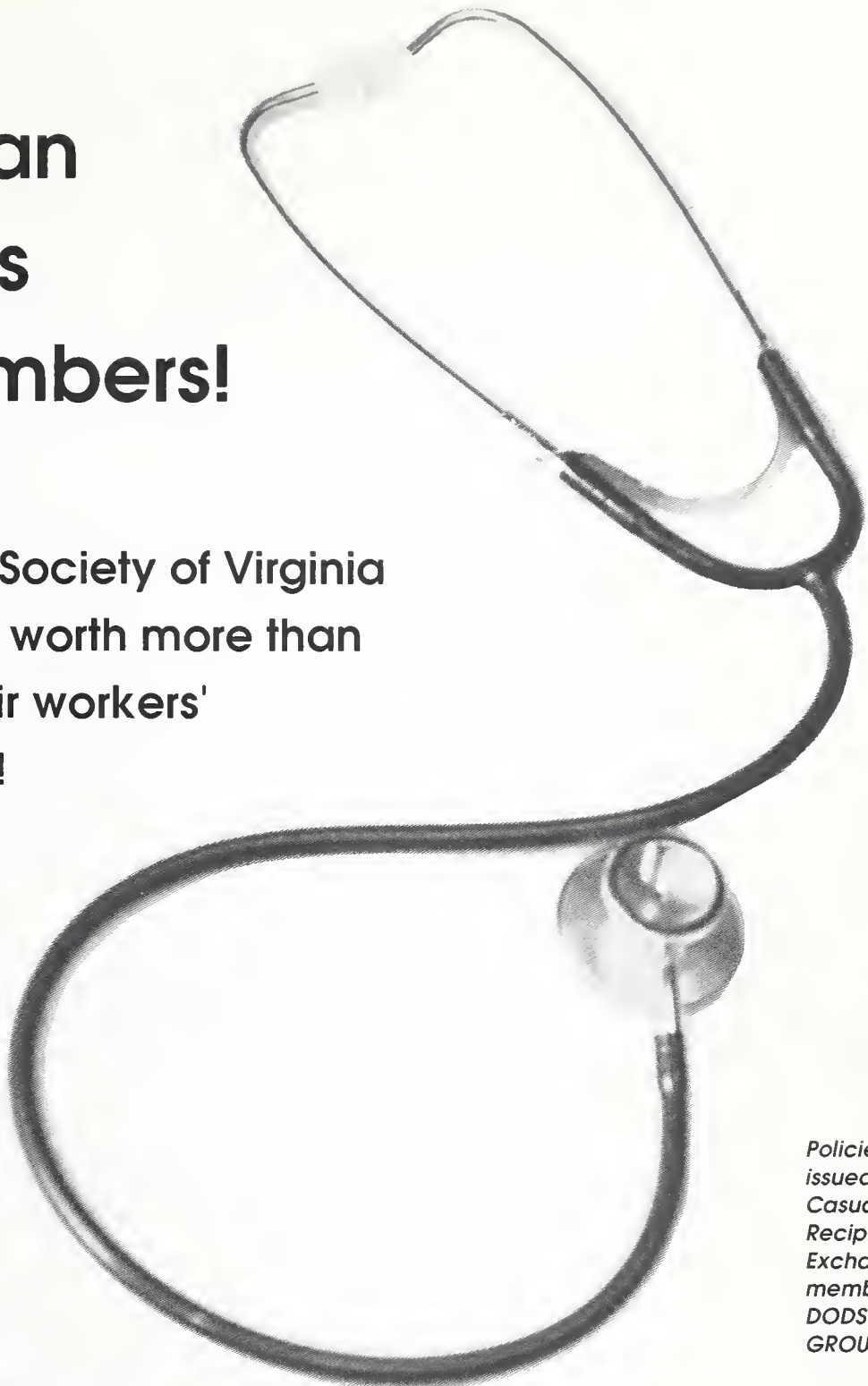
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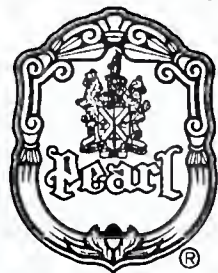
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# LETTERS

## RBRVS: "Good for patients, good for physicians"

Why should physicians continue to support the Resource Based Relative Value Scale (RBRVS)?

The Federal Government and numerous associations are continuing to address changes in national health policy. The Physician Payment Review Commission has supported the implementation of a new Medicare fee schedule based on RBRVS. Physicians need to band together to be sure health policy and payment reform are based on something rational and statistically valid, such as the RBRVS. Failure to support RBRVS will allow the Federal Government and the Health Care Financing Administration to divide and conquer different segments of the medical profession.

RBRVS supports the concept of increased value (and therefore possibly improved reimbursement) for evaluation and management services. RBRVS is not, as some physicians think, just a way to cut surgical fees. It is a way to support the idea that all physicians are "thinkers" and not just "technicians" who do procedures. The Evaluation and Management part of every patient-physician encounter should have a higher relative value. If Congress passed the Medicare Budget as recommended at a "budget neutral" fee schedule, then Evaluation and Management services in all specialties would increase by 30%.

Even if Congress tries to cut the budget from 1991-1996, RBRVS helps improve Evaluation and Management reimbursements. A \$30 office visit with 15% inflation update and a 10% budget cut below inflation goes to \$31.05 *without* RBRVS but would be \$40.36 *with* RBRVS. Since Congress is already in the budget cutting mode, RBRVS helps protect all physicians.

Surveys of patients say that the main desire of patients is more time with their doctor to understand their particular problem. RBRVS allows physicians to do that without their medical business suffering. Preventive medicine is supported and high technology services may be limited some by RBRVS. This may serve to actually help control health costs for all society in the future. Increased time with patients also improves physician-patient understanding and may lead to decreased physician malpractice suits.

The main reason to support RBRVS despite potential problems with actual implementation is that the medical profession can actually be "for" something—rather than complaining and reacting to something.

DAVID W. MACMILLAN, M.D.

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James L. Moore, Jr., *Executive Vice President*

Everyone agrees that there needs to be improved access to care at reasonable costs. RBRVS works for our patients and for a rational payment system for doctors. Rather than internally squabbling, uniting behind RBRVS allows Medicine as a whole to work together to stave off additional Medicare budget cuts. Almost all medical associations testified recently to fight HCFA's proposals to lower the conversion factor. For those who do not approve of RBRVS, other options like mandatory assignment, MD-DRGs and arbitrary government fee limits would be even more onerous.

Physician payment reform is an upcoming fact. Working together to support RBRVS makes the ideas of improved access, preventive care, and protection for undervalued evaluation and management services part of payment reform. It helps unify the profession behind a rational system and allow us to work together to have fairness put into the Medicare system now and in the future.

**John M. Daniel III, MD**

Immediate Past President,  
Virginia Society of Internal Medicine  
7301 Forest Avenue, Richmond VA 23226

**Editor's Note:** More on RBRVS in this issue on pages 142-149 and 181.

## DDS given expanded scope for evaluation of children

Disability Determination Services (DDS) is the division of the Department of Rehabilitative Services which administers the Social Security Disability and Supplemental Security Income (SSI) programs in Virginia. Under the SSI program, parents who meet income and resources eligibility requirements may apply for benefits for their disabled children.

A recent landmark Supreme Court decision, *Zebley vs Sullivan*, has resulted in significant revision in the way DDS evaluates childhood disability. Previously, if a child failed to meet the strict medical criteria for disability, he or she was denied benefits. Now consideration must be given to how the severity of the physical or mental impairment affects the child's ability to function in the normal daily activities of the home and school setting.

The *Zebley* decision will result in a greatly increased workload for DDS. In the next year, about 3,000 previously denied children's claims must be reexamined by Virginia DDS under the new evaluation process, and future applications will no doubt increase.

On behalf of Disability Determination Services, we ask for the cooperation and assistance of Virginia physicians in the face of increased requests from DDS for medical evidence of record and consultative examinations on childhood disability applicants. If you are a



pediatrician and interested in a part-time position, as a consultant in one of DDS' four regional offices, please contact the administrative office, (804) 367-0186.

If you wish additional information about Zebley, please contact us at the above number. If you know of potentially eligible children, please direct the parent(s) to the local Social Security Office, where applications are taken and forwarded to DDS. Your help will be greatly appreciated.

**William D. Rusher, MD**

Associate Chief Medical Consultant  
Department of Rehabilitative Services  
Disability Determination Service  
4901 Fitzhugh Avenue, Richmond, VA 23230

### Adds to a great mentor's principles of practice

I am always glad to see something written by Dr. Kinloch Nelson, (one of my greatest mentors), especially his nine (9) "Principles of Practice for the Male Physician."<sup>1</sup> I would like to add two additional principles which Dr. Nelson taught us.

1. Make a point to brag on the last doctor who has seen the patient because you might be next on the hit list.

2. Charge a fee for your service regardless of the ability to pay. If you do it "for free", most patients will say that free advice is not worth a damn, so the doctor must not be very good.

**John W. Painter, MD**

1300 Thornton Street  
Fredericksburg VA 22401

1. Nelson K. Principles of practice for the male physician. VMQ 1991;118:118

### Professional courtesy: "sucked into the maw"

Whether professional courtesy is legal or not is of minor import.<sup>1,2</sup> The right of the physician to grant this privilege has been sucked into the all-embracing, impersonal maw of the billing-office computer. I know several doctors who have been billed by colleagues who had no intention of charging for their services—but the computer ignored their wishes. GIGO!

**F. J. Spencer, MD**

560 Caroline Drive  
Ruther Glen VA 22546

1. Turner JC. Professional courtesy defrauds, say health insurers (le). VMQ 1991;118:6  
2. ELKjr. Professional courtesy (ed). VMQ 1991;118:53

**Editor's Note:** Most physicians are in agreement. Professional courtesy should and usually does continue.

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# 31st Reprise of a Trip to the Hill

Notes and photographs from the 1991  
Congressional Lunch and briefings

**T**hirty-one years have passed since the Medical Society of Virginia's officers initiated the annual visitation to Washington that came to be known as the Congressional Luncheon. The lines of communication with the state legislature were strong and secure, thanks in no small part to the presence in the General Assembly of six physicians, but ties to the Virginia delegation on Capitol Hill left something to be desired. When, in 1960, Executive



**MSV President John A. Owen, Jr. (left), welcomes the new 8th district congressman, James P. Moran, to the Congressional Luncheon in the Gold Room of the Rayburn Building as Dr. Ira J. Green of Alexandria, MSV councilor for the 8th, looks on. In the foreground, Sen. Charles S. Robb. Moran, former Alexandria mayor, unseated long-time congressman Stanford Parrish in 1990.**



Secretary Bob Howard suggested that the leadership needed a trip to Washington "to learn as much as possible about the relative value schedules,"<sup>1</sup> the annual trip to the Hill was launched. The fee schedules he was referring to had been developed by the California Medical Association and picked up by some three dozen state/other medical organizations over the country.

Fee schedules were still a hot topic in Washington when the 1991 Congressional Luncheon was held

on May 8, but there were some differences. The fee schedules being talked about forty-one years ago were born at CMA headquarters in Los Angeles in 1956 and killed by Big Government in Washington in 1974. Today's schedule, the Resource-Based Relative Value Scale, was promulgated by Big Government, and whereas the CMA schedules were based entirely on what California doctors were charging, the RBRVS for Medicare takes into account prevailing charges all over

the country and also figures in physicians' costs, such as overhead and malpractice expense. Those are differences. Are there similarities?

For an answer, we consulted Dr. Byron C. Pevehouse of Alexandria, who at an earlier time was a pillar of CMA (and chief of neurosurgery at Presbyterian Medical Center in San Francisco) and is now director of health policy and professional affairs for the American Association of Neurological Surgeons.

"They're just reinventing the



At left on the balcony of the Gold Room is Owen B. Pickett (D-Virginia Beach), who moved from Virginia's House of Delegates to Congress in 1987, with Dr. Russell D. Evett, Norfolk, MSV councilor for the 2nd district.



Dr. George B. Craddock, Jr., Charlottesville (left), MSV vice councilor for the 7th district, and Congressman D. French Slaughter, Jr. (R-Culpeper), who is in his third term for the 7th.



wheel," is Dr. Pevehouse's déjà vu. "The CMA Relative Value Study did it just about the same way they're doing it now. We had a conversion factor. We had quality assurance. We had 3-digit codes, then 4- and finally 5-digit codes—which the AMA later incorporated into its CPT-4 coding. We had all that stuff." The Study was published regularly as a book, he recounted, and sold to anyone who wanted it.

What happened to it?

"Senator [Edward] Kennedy began agitating for national health insurance," Dr. Pevehouse related, "then the Federal Trade Commission started investigating for anti-trust violation, putting on a lot of pressure, demanding records and the like. Finally the CMA agreed to cease all relative value activities. Thereafter new procedures were individually priced without any kind of peer review, and we had the chaos and exploding costs of MediCal, which led us to where we are now.

"You know who picked up on the RVS after the FTC did it in?" He laughed ruefully. "The West Germans. They took it into the national health system they enacted in 1975 and it has functioned very well for them. Their federal medical association determines the relative value for a service and local medical groups negotiate with sickness funds on the conversion factor to determine actual payment."

**G**ail R. Wilensky, economist (PhD, Michigan U), wife of a plastic surgeon, and Administrator of the Health Care Financing Administration, finds merit in the German system. Speaking to the Medical Society of Virginia delegation in a conference room of the Health and Human Resources Building, she termed the Canadian system "irrelevant" but thought a lot could be learned from the West Germans, especially in regard to



**Two from the 9th district: at left, Frederick B. (Rick) Boucher (D-Abingdon), congressman since 1982, with Dr. Palmer W. Fant, Independence, MSV councilor.**

high technology and volume performance standards.

In this country, "health care is ripe for discussion," she believes. "There has been intense interest across the political spectrum for the last couple of years. I think rising frustration with costs is driving this interest," she told the doctors, "and although there's a lot of talk about access and the uninsured, cost is definitely the primary concern. I don't think anything will be done about access until something is done about costs."

One of the listening physicians had a question. The affluent elderly receive the same Medicare benefits as the indigent, he said. In the mid-Eighties the American Medical Association was pushing hard for a means test to address this situation. Is anything of this nature in the works now?

The Administrator found the inquiry apt because, as she put it matter-of-factly, "the program is due to go belly up in 2008."

"Ultimately, we will have to make a very modest entree into income-related Medicare financing," she answered the physician. "And then we'll have to move on the catastrophic coverage problem, which will be much,

much more difficult because it is so touchy politically.

**T**o one of Mrs. Wilensky's top officials, Kathleen A. Buto, fell the greater part of the briefing. Mrs. Buto (MBA, Harvard) directs HCFA's Policy Development Bureau, which works up prospective payment system rates for hospitals, physician fee schedules, Medicare coverage rules for technologies and procedures, and conditions of Medicare participation for hospitals, nursing homes, and home health agencies.

Implementation of the RBRVS is an "enormous operational effort," she said, and she proceeded to describe how the coming fee schedule had been formulated, converted, coded, adjusted, budget-neutralized, and otherwise shaped.

Biggest hurdle in the fee schedule's formulation, Mrs. Buto related, was Congress's order that there must be budget neutrality in 1992. How do you figure for 1992 when you don't have the 1991 data? You age the 1989 figures, Mrs. Buto said, and you project.

The most contentious projection, she said, is the 1% conversion factor designed to deal with the





From left, Frank R. Wolf (R-Vienna), for 11 years the 10th district's congressman, with two constituents: Dr. Ira D. Godwin, Fairfax, MSV councilor, and Dr. William A. Hazel, Jr., McLean, chairman of the AMA's Young Physicians Section.

anticipation that when physicians' fees go down, as most of them will, the volume/intensity of services will go up. HCFA, the Congressional Budget Office, and the Physician Payment Reform Commission are agreed that this compensatory action is bound to happen, Mrs. Buto explained, and that a 1% reduction in the fee schedule is necessary to allow for it.

A lot of physicians perceive this 1% conversion factor as punitive. One of the MSV members listening to Mrs. Buto gave voice to that perception.

"You're proving us guilty without a trial," he protested. The objection distressed Mrs. Buto.

"We aren't accusing you of anything," she said anxiously. "It isn't a crime, it isn't illegal, to make up for lost income by adding



On the left, Congressman James R. Olin (D-Roanoke), who is in his fifth congressional term for the 6th district, and Dr. Kenneth D. Tuck of Roanoke, MSV councilor for the 6th.

# ON CAPITOL HILL

## To statesmen in a quandary: “Face the voters and tell it like it is.”

*This is the text of MSV President John Owen's address at the Congressional Luncheon on May 8 in the Gold Room of the Rayburn Building in Washington.*

**M**EMBERS of the Virginia Congressional Delegation, I welcome you to this lunch and would offer a few brief remarks.

Someone has likened our annual luncheons at the Capitol to those delegations of native Americans who so often came to Washington, over a century ago, to smoke the peace pipe with the Great White Father and to receive his assurances that there were no plans to further invade the tribal lands and certainly no plans to confine them on a reservation. These assurances we value quite highly, even as in those days of old.

This trip will be a little different since in addition to our usual topics of discussion I propose one which is certainly unique for our two groups: an account of how one man can influence national policy. The case in point is a tribute both to the American medical profession and to the Congress of the United States.

We bring with us today one of our own, a physician of whom we are truly proud, Dr. Joseph Chemplavil of Hampton, Virginia. Most of you are surely well aware that he initiated an extraordinary chain of events during the War in the Persian Gulf by publicly circulating a notice that he would no longer require co-payment on the billing of CHAMPUS for services rendered to dependents of those who were serving in Operation Desert Shield. And he found at once that his charitable, patriotic, and self-sacrificial gesture was immediately wrapped in red tape and threatened with fatal suffocation. Apparently it is highly irregular, if not illegal for a physician to voluntarily surrender a claim on a patient's fee for any reason. Such is life in these United States in 1991.

But the story has a happy ending because the publicity given to Dr. Chemplavil's predicament by

the American Medical Association and local press came to the attention of Representative Young of Florida, and his amendment to the Operation Desert Shield/Desert Storm Supplemental Appropriations Act allows physicians to waive CHAMPUS co-payment for dependents of military personnel in the Persian Gulf conflict. President Bush has signed the bill and the Chemplavil modification is now the law of the land. We are so proud of our colleague, and so grateful to you, our congressional representatives, that we invited Dr. Chemplavil to come with us to Washington where, if you hold your lanterns high above your heads, you will find revealed an honest man.

**N**ow the question may arise, why, if the medical profession and Congress can work together so smoothly and briskly and well in this situation, can't we do it all the time? The answer, I suspect, is that patriotism is a great legislative lubricant. But since we have worked with and appreciated each other so much in this case, can we not take on another endeavor?

To that end, we have brought with us another young physician, Dr. William Hazel, of Fairfax. Dr. Hazel would like to draw your attention to the stipulations of Medicare reimbursement which limit a physician in his first year of practice to 80% of the standard rate, to 85% in the second year, to 90% in the third year, 95% in the fourth year, and only after five years of practice is he entitled to collect the same Medicare fee for the same service that we old gray-beards can command. Since the service is the same, and the patient satisfaction not demonstrably different, we ask you, Is it fair to penalize physicians for their youth, adding insult to their financial injuries, e.g., their medical school debt servicing hanging over their heads? I am tempted to ask Mr. Moran, our newest congressman from the Eighth District, how he would feel if the law required



him to serve for five years, meaning two reelections, before his salary as a Congressman would equal that of his neighbor Mr. Wolf? At any rate, Dr. Hazel tells us that help is on the way in the form of HR1898, introduced by Congressman Towns of New York. Please support this bill that will help young physicians everywhere.

Finally, I would like to introduce Dr. Steven Vaughan, past president of the Old Dominion Medical Society. This year both groups have recognized the obvious, that both black and white physicians in Virginia face the same problems and challenge, hence might profitably collaborate on legislative matters. So it seemed and so it has turned out, and we at the Medical Society of Virginia look forward to an ever-closer collaboration in the years to come.

**T**HERE is a great debate about the direction of our national health policy nowadays. One can hardly pick up a newspaper or magazine, or watch Walter Cronkite on TV, without learning about the catastrophic state of the American health care system, and the urgent need to do something. It is clear already that at least five major groups—business, labor, the insurance industry, the health professions, and the consumers (aka taxpayers), all have their own agendas, their own priorities, and often their own implacable insistence on what should *not* be done. Therefore the debate threatens to be intense, acrimonious and endless. What is a poor statesman to do in a quandary like this?

Schizophrenically, the pundits are complaining on the one hand that we are already paying far too much for health care, and concerned, on the other hand, that no one is paying anything for the health care of 33 million people without health insurance. Somehow no one has figured out a way whereby we can spend less and get more. It seems to me that we cannot resolve these two diametrically opposite problems without (1) a further outlay of billions for the uninsured, or (2) a drastic reduction in health care for the already insured, or (3) involuntary and unpaid servitude for all health care professionals for the rest of their natural lives—or perhaps a miraculous doubling of the Gross National Product. Which of these do we really want and how do we get there from here? Whereas the most sensible solution for most of us appears to be a bare bones insurance coverage for everyone with maximum co-pay and deductible, what America wants is unlimited health care for everyone with first-dollar coverage and no co-pay.



**Dr. Joseph K. Chemplavil, Hampton (left) whose role in spurring Congress to change a CHAMPUS regulation is described by Dr. Owen, and Dr. C. Barrie Cook, Falls Church, photographed at the HCFA briefing.**

One of the things we learned in kindergarten was that you can't have your cake and eat it too. Yet when we consider the short and unhappy life of the catastrophic health insurance plan, of dear departed memory, we have to admit that few Americans see it that way. Somebody, some time, is going to have to tell America that you get what you pay for—and it looks like you're elected.

**G**ENTLEMEN of the Congress of the United States, we cannot by ourselves educate the entire nation, but we here have a deep and noble responsibility to educate the people of the Commonwealth of Virginia. Let us educate ourselves as to the pros and cons, risks and benefits, gains and losses of each potential plan and let us go forth together, unafraid, to face the voters of Virginia and tell it like it is.

The task is enormous. We can only succeed if we work together in trust and mutual support. If you will pledge today, faithfully and conscientiously, to spread this message in all your political discussions, we as a medical profession will be proud to work with you to translate your policies into our realities. Can we bury the hatchet and smoke the peace pipe on that?

JOHN A. OWEN, JR., MD, President,  
The Medical Society of Virginia



**HCFA Administrator Gail R. Wilensky in the spotlight at the briefing for Medical Society of Virginia officers and councilors. Half-hidden immediately beyond her is Dr. Nancy E. Gary, HCFA's senior medical advisor, and to Dr. Gary's left is Kathleen A. Buto, director, policy development bureau.**



**Dr. H. C. Alexander III, Roanoke**



**Dr. William H. Barney, Lynchburg**



**Dr. George E. Broman, Culpeper**





From left, President Owen, Dr. William J. Hagood, Jr., Clover, and Dr. Harold L. Williams, Newport News

more service; it's just human nature and happens in all sorts of settings all the time." Besides, she added, the 1% conversion factor is just for 1992; thereafter the Value Performance Standard mechanisms will take over.

The geographical element in the scale prompted a question from another doctor.

"Will we see real geographical differences in fees around the country?" he asked. Yes, you will, Mrs. Buto replied, and "I believe they will be more rational." She cited an example: in New York State, fees generally will come down from a very high index, and in Louisiana fees generally will go up from a very low index, but fees in New York will still be higher than in Louisiana.

As for the prodigious changeover to uniform coding, an estimated 4,000 procedures have been entered, she related, and lots of research is still going on in that department. Which reminded one of the visiting physicians of Medicare paperwork.

"I have read that 37 cents out of every health care dollar goes for paperwork," he said. "Can't you do something about that?"

Nancy E. Gary, MD, HCFA's Senior Medical Advisor, was moderating the briefing and jumped in to answer. She was dean and professor of medicine at Albany Medical College in New York

before moving to HCFA in 1990.

"I agree that the paperwork burdens for physicians are very heavy," Dr. Gary said, "We have a committee looking into ways of lowering the paperwork." To which Mrs. Buto quickly added, "Only 3 cents of every *Medicare* dollar goes for paperwork."

Twenty-five Virginia physicians listened as the three HCFA officials spoke. In conversation after the briefing, Mrs. Buto commented on the size of the delegation. Many medical organizations come to HCFA for briefings, she related, but with few exceptions the delegations are small—two or three representatives is the norm.

"I was so surprised to see so many doctors from Virginia," she said. "It was an impressive delegation."

**E**arlier in the day, at breakfast, the visiting physicians heard from Fitzhugh S.M. Mullan, MD, who was trained as a pediatrician but now heads the National Practitioner Data Bank. He showed up in the starchy whites of the United States Public Health Service, where his title is director of the Bureau of Health Professions, Health Resources and Services Administration.

Describing the Bank generally as a "controversial program, mildly complicated, with a regulatory bureaucratic aspect," Dr. Mullan outlined the who, what, how, when, and why of the reporting and access mechanisms.

"The Bank is unique," he summed up. "There is no other place in this country where this data is being aggregated." Its information will be particularly helpful to the peer review process, he predicted, providing "one-stop shopping" for those in peer review so that they can "make sure they are playing with a full deck"—a full deck of info on the person under review, that is.

At that time the Bank had fielded a total of 487,911 inquiries and

16,073 reports, Dr. Mullan said, and of the reports involving physicians and dentists, 85% concerned malpractice. Ways are being investigated to expedite inquiries/reports, he noted—a diskette system for hospitals, for instance. Despite concerns to the contrary, the Bank is functioning competently, Dr. Mullan asserted, and "is going to give all of us, patients and physicians, more confidence in the [health care] system."

To a question about the rights of the person who has been reported, Dr. Mullan answered with this sequence: the person is notified of the report; he has the right to dispute the report in matters of *fact* but not of interpretation; to do so, he registers the disputed facts with the Bank, then takes up the disputed facts with the reporting entity; if errors are proved, the file is changed; if the report is deemed correct, it stands as submitted, but the reported person can ask the Secretary of HHS to take up the dispute, "which is a much lengthier process." The Bank is not an appellate court, Dr. Mullan emphasized, i.e., "it cannot be reviewed or second-guessed."

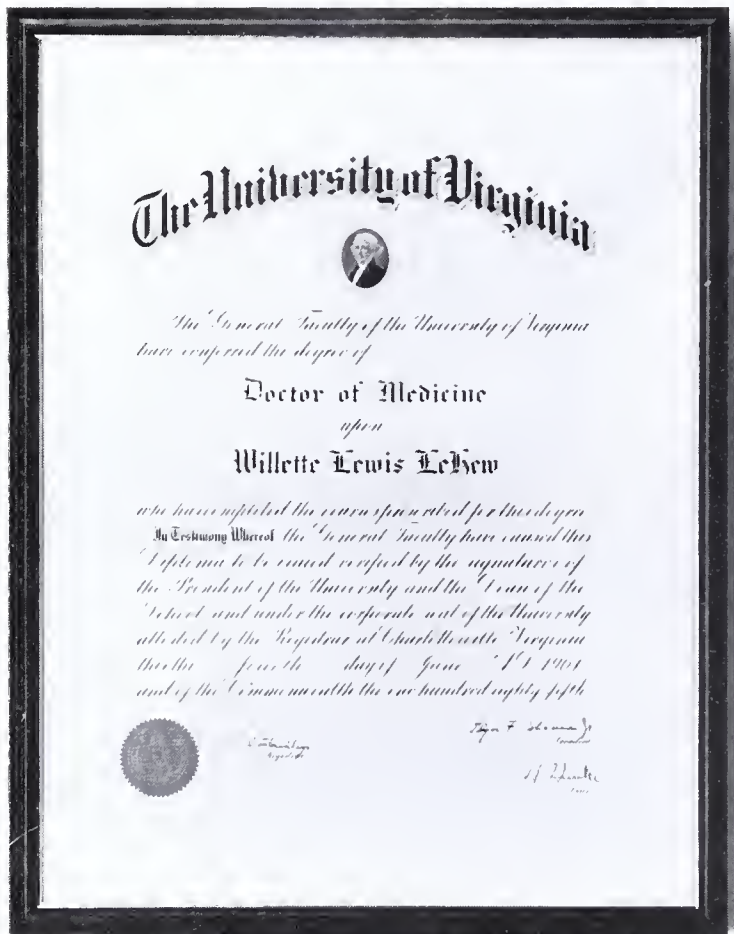
What about cases that are settled by the carriers without consulting the doctors involved, a physician asked. Do those paid claims have to be reported?

The federal law as written says "any malpractice payment" must be reported, regardless of the amount or how the settlement was made, answered Dr. Mullan. He noted, however, that in California malpractice payments below \$30,000 do not need to be reported to the Medical Board of California, which licenses physicians, and he thinks that floor is "a good idea."

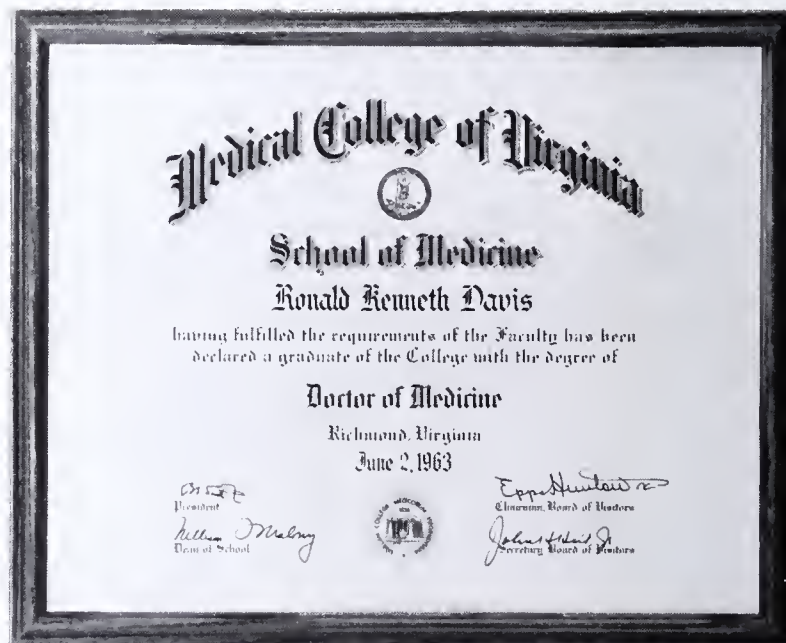
—ANN GRAY

1. Howard RI. Report of the Executive Secretary-Treasurer. *Va Med Mon* 1960;87:510-11

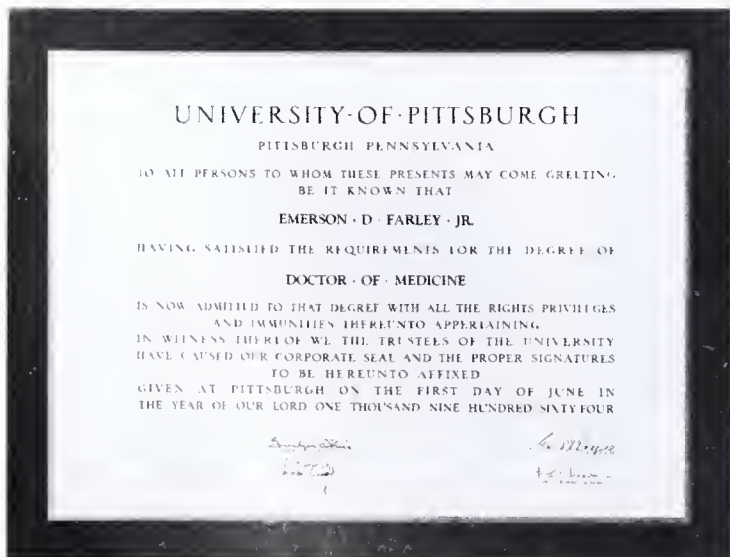
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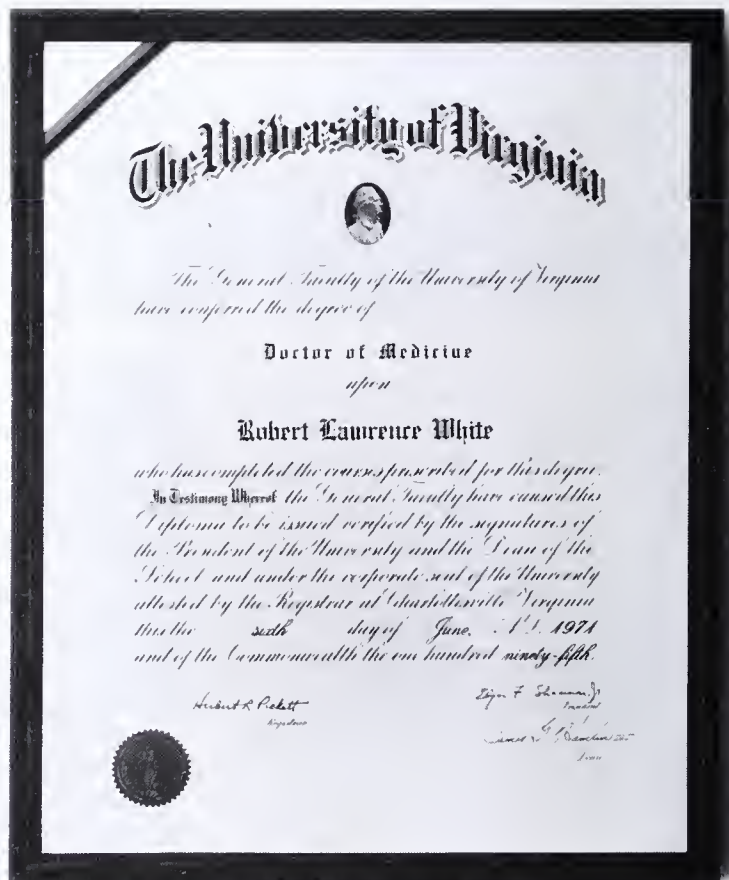
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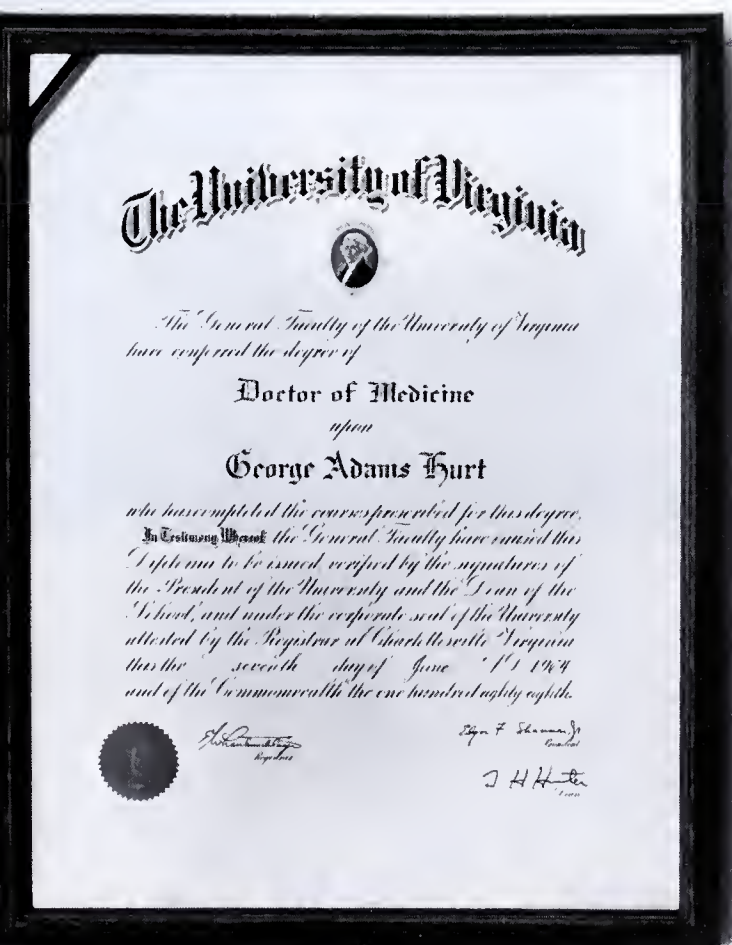


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# MEETINGS

**1991 Annual Meeting,  
The Medical Society of Virginia,  
November 6-10, Williamsburg**

**August 2-4**

**8th Annual National Clinical Care Diabetes Conference: Diabetic Neuropathy** (Eastern Virginia Medical School), *Virginia Beach*. Jeanette Schmitz, 804-446-6143.

**August 5-9**

**1991 Summer Symposium: Trauma, an Emergency Physician's Perspective** (Virginia Chapter, American College of Emergency Physicians), *Virginia Beach*. 27 credit hrs. Gwen E. Harry, 804-966-5966.

**August 7-11**

**Annual Meeting, Southern Orthopaedic Association**, the Broadmoor, *Colorado Springs, Colorado*. 205-945-1848.

**August 8-11**

**15th Annual Summer Retreat: Practical Issues in Primary Care** (Medical College of Virginia/VCU), *Virginia Beach*. CME Office, 804-786-0494.

**August 14-17**

**Annual Meeting of the West Virginia State Medical Association**, the Greenbrier, *White Sulphur Springs, West Virginia*. Nancie Divvens, 304-925-0342.

**August 15-18**

**Plastic Surgery of the Eyelids and Orbit/Oculoplastic Surgery: Aesthetic and Reconstructive** (Eastern Virginia Medical School), *Virginia Beach*, Jeanette Schmitz, 804-446-6143.

**August 16-18**

**7th Annual Conference on Primary Care of the Female Patient** (Medical College of Virginia/VCU), *Virginia Beach*. CME Office, 804-786-0494.

**September 4-6**

**6th Annual Postgraduate Course: Update in Film Screen Mammography** (University of Virginia), Jefferson Sheraton Hotel, *Richmond*. 20 credit hrs. Fee: \$425. R. L. Boswell, Program Coordinator, 804-924-9387.

**September 13-15**

**20th Annual Diagnostic Ultrasound in Gynecology/Obstetrics and Abdomen** (Johns Hopkins), Marriott Inner Harbor Hotel, *Baltimore*. 16.5 credit hrs. CME Office, 301-955-2959.

**September 14**

**Regular meeting of the Medical Society of Virginia's Council**. *Richmond*. James L. Moore, Jr., 804-353-2721.

## **Pediatric Advanced Life Support Provider Course**

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**September 19-21**

**Virginia Occupational Health Conference** (Eastern Virginia Medical School), *Williamsburg*. Jeanette Schmitz, 804-446-6143.

**September 20**

**14th Annual Perinatal Conference** (Medical College of Virginia), *Richmond*. CME Office, 804-786-0494.

**September 21-23**

**Annual Meeting of the Virginia Vascular Society**, Tides Lodge, *Irvington*. Dr. Walter H. Graham, 804-596-7631.

**September 25-28**

**Management of the Spinal Cord Injured Patient** (Eastern Virginia Medical School), *Virginia Beach*. 16 credit hrs. Fee: \$225. CME Office, 804-446-6140.

**October 7-10**

**14th Annual Postgraduate Course in Practical Radiology** (University of Virginia), Boar's Head Inn, *Charlottesville*. 20 credit hrs. Fee: \$400. R.L. Boswell, Program Coordinator, 804-924-9387.

**October 9-11**

**17th Annual Topics in Gastroenterology and Liver Disease** (Johns Hopkins) *Baltimore*. 24 credit hrs. Fee: \$450. CME Office, 301-955-2959.

**October 12-13**

**Pediatric Advanced Life Support Provider Course** (Mary Washington Hospital), *Fredericksburg*. Limited to 24 students. Dr. Melville G. Wright III, 703-899-1326.

*More meetings next page*

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## MORE MEETINGS

### October 14-19

**33rd Annual Emil Novak Memorial Course in Gynecology, Gynecological Pathology, Endocrinology, and High Risk Obstetrics** (Johns Hopkins), *Baltimore*. Fee: \$650. CME Office, 301-955-2959.

### October 18-20

**39th Annual Pulmonary Conference** (Virginia Thoracic Society), Fort Magruder Inn, *Williamsburg*. Carl Booberg, 804-355-3295.

### October 24-30

**5th Annual Postgraduate Course in Emergency Medicine, a Comprehensive Review** (Johns Hopkins), *Baltimore*. Fee: \$950. CME Office, 301-955-2959.

### October 26

**20th Annual Symposium: Management of Fractures of Femur and Tibia** (National Hospital for Orthopaedics/Rehabilitation), *Arlington*, Medical Staff Office, 703-553-2405.

### November 2-3

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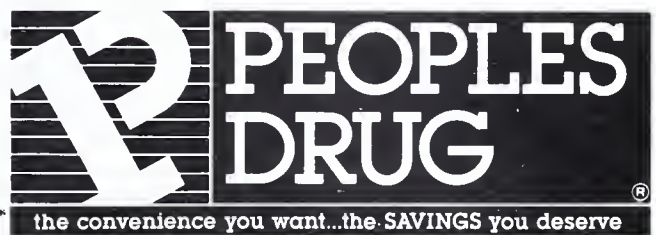
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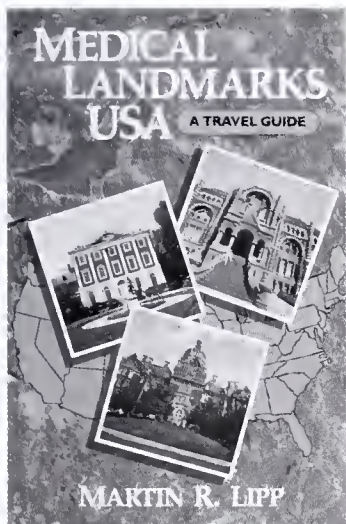




# BOOKS

**Medical Landmarks USA**, by Martin R. Lipp, MD. New York, McGraw-Hill, Inc., 1991, 550 pp, blk/wh illustrations, \$24.95 paperback.

Books are expected to provide us with information or reading pleasure. This book does both but has some definite gaps on the information side. Dr. Lipp, who is in general practice with the Kaiser Foundation Health Plan in San Gilroy, California, states four goals for this book: It is a travel guide, a reference work, an anthology of stories and a history text on health care in the United States. The travel-guide goal is the strongest of the four. A visitor can look up the name of a city or state and then quickly read about the medical facilities and medical historical sites located there. However, not every medical facility is listed and some of the historical sites have only a loose association with medicine (Arlington National Cemetery, for example.).



Dr. Lipp begins his book by discussing seven "great medical cities." Over 200 pages are devoted to Baltimore, Boston, Chicago, New York, Philadelphia, Rochester, Minnesota, and Washington DC. Washington has never been on my list of medical meccas even though it contains four medical schools and many hospitals. However, several of the historical buildings and museums with a medical orientation are included in this chapter which, with a little stretch of the imagination, could bring Washington a notch or two closer to Boston or Philadelphia. Other cities with significant medical histories are saved until the state

by state chapters in the second part of the book. Here one can read about the Menninger family and the Ochsners and the hundreds of other great and near-great medical families and facilities in the United States. Hunting up some of these takes patience since the states are presented alphabetically but without page headings, which would have made finding a particular facility easier. The index is good, however.

Having lived in some near-great medical cities (Wichita, Kansas; Louisville, Kentucky; Gainesville, Florida; and Richmond, Virginia), I was disappointed when reading the brief notations of these cities. Wichita is not listed. I did not get a feel for the University of Louisville School of Medicine and the large medical complex on its campus. The same can be said for the University of Florida's Shands Teaching Hospital or, for that matter, the Medical College of Virginia (called "Virginia Commonwealth University—Medical College of Virginia Medical Center," a name with which I am not familiar). Only the Egyptian Building and West Hospital are discussed and a brief history of MCV is given. Nothing is said about the rest of the campus, the new hospital which was opened in 1982, nor of the important research or patient care given at this, the largest medical teaching institution in Virginia. Also missing were historical notations about Richmond's role as a medical center for the South during the War Between the States, while much space is devoted to this subject from a northern perspective in the chapter on Washington.

To the credit of the author, considerable space is given throughout the text to the historical importance of minority medical schools and hospitals. Dr. Lipp also gives space to facilities that practice or practiced non-traditional methods of healing (e.g., chiropractic practice, Christian Science reading, homeopathy).

I'm not sure that I would shell out \$24.95 for my review copy of this book but I may want to refer to it prior to a trip to one of the seven major medical cities.

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# Post-Acute Management of Head Injuries

Henry H. Stonnington, MD, *Richmond, Virginia*

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Many advances have been made in the last 15 years in the treatment of traumatic brain injuries. This paper reviews the advances not only in the acute management stage but also in the crucial rehabilitation phases, both acute and post-acute. Rehabilitation of the brain-injured patient has been shown to result from therapies rather than sponta-

neous improvement and take years to accomplish, emphasizing the need for a coordinated continuum of rehabilitation programs. There is now evidence that coma and vegetative states are sometimes reversible with a combination of treatments, among them neuropharmacology. *Va Med Q* 1991;118(2):159-161, 164-165

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**H**HEAD INJURY has been called "the silent epidemic". This implies that there are a large number of head injuries in the population. A review of the epidemiology of head injury shows how varied the studies are and how difficult they are to interpret.<sup>1</sup> We are dealing with an injury that can be severe, moderate or mild but the outcome does not necessarily follow that initial pattern. There are patients with mild injuries whose outcomes are tragic from a social, cognitive and behavioral point of view.<sup>2</sup> The initial injury, whether severe or mild, has a profound impact on many parts of the brain and affects all functions. The outcome is not just death or survival but can be a vegetative state or a variety of physical, cognitive and behavioral impairments which have far-reaching social and environmental consequences. Proper management of these injuries has greatly improved the outcome.<sup>3-5</sup> What is more, improvement in outcome can occur for years after the incident.<sup>4,5</sup>

Dr. Stonnington is medical director of Sheltering Arms Rehabilitation Hospital, Richmond, and editor in chief of the international journal, *Brain Injury*. Address correspondence to him at the Hospital, 1311 Palmyra Avenue, Richmond VA 23227. Submitted 2-6-91.

It is the object of this paper to describe the methodology by which these improvements can be achieved.

## **Incidence, Prevalence, Costs**

The reported incidence of head injuries varies considerably. Jagger et al,<sup>6</sup> reporting the incidence in rural Virginia, finds the incidence 208 per 100,000. Annegers et al<sup>7</sup> agree that in a survey of their small town and rural community of Olmsted County, Minnesota, there was an incidence of 195 per 100,000. Klauber,<sup>8</sup> evaluating San Diego County, found the incidence 295 per 100,000. The National Health Interview Survey found there were 7,560,000 head injuries, of which 1,250,000 were severe.<sup>9</sup>

If we talk about prevalence, we are talking about numbers of people in the population actually living with the condition. One estimate of the prevalence rate for moderate and major brain injuries is 27 per 100,000 population within the United States as a whole.<sup>1</sup> This does not include the mild head injuries, which it is now known can cause major disabilities<sup>2</sup>; 79% of these victims are younger than 30 years<sup>2</sup> and have a life expectancy of 44 years.

The financial burden on the individual, the family,

## Reversing Coma

There is a group of brain-injured patients who go from coma to a "locked-in syndrome." The majority of these patients have severe brain stem injuries and often remain in deep coma for quite a long time. They may need respiratory support, are unable to swallow, unable to move and are severely spastic. It is a tragedy to misdiagnose these patients as "vegetative," as they may well have a brain which becomes fully aware of its surroundings when awakened from coma. Some improve dramatically, others can learn to use environmental control and augmentative communication devices and eventually have a fairly good quality of life. Other types of patients in coma go on to a vegetative state when they have reflexive reactions but still appear to be unaware of their environment. We now have evidence that all patients in coma or in the vegetative state should be given the chance of going through a proper arousal program, as some of them can be made conscious again. There are pharmacological interventions, together with the intensive rehabilitation program, that have some remarkable results, particularly with the use of dopaminergic drugs.<sup>12,13</sup> Reversal of the vegetative state has also been described with the use of chronic electrical stimulation of the mesencephalic reticular formation.<sup>14</sup> There is now good clinical and basic scientific evidence that a combination of pharmacological intervention and intense rehabilitation methodology can bring about reversal of the coma, vegetative state, and locked-in syndrome, as well as all other post-traumatic brain-injury syndromes.<sup>15-19</sup> —H.H.S.

the community and the country is enormous. One study<sup>10</sup> demonstrated that the long-range cost of head injuries can run to well over a million dollars; the initial hospitalization alone is on average about \$100,000. In addition, there are the costs of loss of employment, loss of home, and a loss of income to the family, not to speak of the loss of tax revenue to the country. Therefore, any improvements in any aspects of care is a great benefit to everyone concerned.

### Emergency/Neurosurgical Care

The head injury itself is only the beginning of the problem. The fall of blood pressure, the loss of cerebral blood flow and the increase of intracranial pressure, which, if not prevented, rapidly follows a brain injury, can cause as much if not more damage than the initial injury. Thus a well-trained emergency service bringing the patient to a recognized trauma center is mandatory.<sup>11</sup> Neurosurgeons have developed and are testing a number of new protocols using new method-

ologies and pharmacological agents. They carefully control intracranial pressure, do lobotomies for severely damaged areas and often have to use ventriculo-peritoneal shunts if the intracranial pressure cannot be reversed. A Swedish study<sup>3</sup> compared results of neurosurgical outcomes prior to and after the institution of aggressive management; the mortality decreased from 48% to 35% and good recovery increased from 39% to 54%.

### Acute Rehabilitation

Early involvement of the acute rehabilitation interdisciplinary team, which consists of psychiatrist, neuropsychologist, cognitive retraining therapist, physical/occupational therapists, speech/language pathologists, therapeutic recreational therapists, social workers and rehabilitation nurses, has been proven to make a significant difference.<sup>20</sup> It is also extremely important to regard the patient and the family as very much members of that team. They need to be involved in goal setting and be generally involved. This is particularly so in the case of an agitated patient, where a one-to-one involvement by a family member often makes all the difference. As patients are recovering, there are a number of behavioral scenarios, such as agitation and aggression. The use of carbamazepine, together with a behavioral modification program, is often necessary. Swallowing may be non-existent and the early use of percutaneous enterostomal gastrostomy has been very useful. Only when a modified barium swallow is satisfactory can a swallowing program be started in earnest.

Throughout each day there are many repetitions of the various mobility, self-care, communications, cognitive and behavioral therapies, and slowly, results become apparent. Witnessing these improvements is very rewarding for the team, the patient and the family. Many other factors must be accomplished, such as weaning from the tracheostomy and instituting bladder and bowel programs, as well as facing complicated discharge planning. There is also the question of whether anti-seizure medications should be continued, as these often interfere with the cognitive process. Throughout the rehabilitation process, one must keep alert for the possibility of complications such as infections or the development of a hydrocephalus that may require a ventriculo-peritoneal shunt.

The inpatient rehabilitation program usually lasts several weeks. Even after achieving many goals regarding self-care and mobility, there usually remain behavioral, cognitive, communication and physical problems.

### POST-ACUTE REHABILITATION

Ideally, there needs to be a continuum of programs through which the brain-injured patient can progress. The special programs for various needs that patients



have, whether they are physical, cognitive or behavioral (and eventually vocational), should be carefully coordinated even if it takes years to accomplish the maximum rehabilitation. If this coordination does not exist, the family and patient are left to flounder, thus adding to the frustration, financial cost and poor results.

*Day Rehabilitation Program.* There are several types of day rehabilitation programs. Ben-Yishay's program<sup>21</sup> starts with cognitive remediation, then progresses to occupational trials. Prigatano's program<sup>23</sup> includes simultaneous work trials with intensive cognitive and interpersonal therapies. At Sheltering Arms Hospital we have found that we first need a day rehabilitation program, similar to the inpatient program, except that the patient lives at his/her own home or at an adult home; in this way we can discharge the patient earlier from the more expensive inpatient program and also involve the family more. We transport the patients to and from the program and give them lunch. All day they receive intensive physical and occupational therapies, speech/language pathology, cognitive remediation, behavioral modification and therapeutic recreation. There is a great deal of social intervention and teaching by social workers and rehabilitation nurses. Group programs, psychological support and evaluation by the neuropsychologist is an integral part of the program. As in the inpatient program there are weekly interdisciplinary conferences to provide family and patient a means of discussing goals and objectives and their accomplishments.

We have found that this intensive interdisciplinary program is usually necessary for several weeks before the next stage can be accomplished, which may be a transitional living program or a vocational program. At times we have combined the day rehabilitation program with the vocational program. If the patient's behavior and cognition has improved sufficiently, a work capacity evaluation followed by work hardening often is possible. This occasionally enables the patient to go directly to competitive work. At this stage, a driving evaluation and perhaps a driving re-education program will be necessary.

*Transitional Living Program.* There are a large number of patients who have reached maximum improvement with their physical disabilities, becoming almost independent in mobility and self-care. However, they are still not at a stage when they can be left alone or able to seek employment. They still have difficulties with behavior, communication and cognition. They still have problems with attention, memory, sequencing, perseveration, distractibility and mental rigidity, as well as a variety of unpleasant behaviors. Residential programs<sup>4,5,24</sup> provide remediation for these problems with an initial structure of neuropsychologists and life skill trainers. At first, patients are closely monitored, taken in public transport and taught

generally how to reintegrate into the community. At a later stage, they are less supervised and vocational explorations are started, and in a third stage they are provided with minimal supervision, living in their own apartments and starting actual employment.

*Vocational Program.* One of the great advances in the reintegration of the brain-injured patient is the emergence of "supportive employment".<sup>25,26</sup> The traditional approach of first teaching new job skills and then finding suitable employment usually does not work. Post-traumatic brain-injured patients still have cognitive as well as behavioral problems. As a result, they are unable to stay at one job very long. Because of their suspicious nature and their inability to pay attention, they were often terminated or leave their jobs. In supportive employment programs they have a "job coach" who can prevent outbursts, adjust the work environment and develop good rapport with the people at work. As the brain-injured person and the other workers get used to each other, the job coach withdraws more and more. We have people who had lost jobs consistently but have now worked productively for several years. The important incentive in this program is that the patient receives wages from the start and goes on to hold his/her own in a competitive environment.

*Alcohol and Behavioral Program.* Many of the victims of brain injury had prior problems with substance abuse and behavior which often remain after injury. Special programs need to be available for both alcohol<sup>27,28</sup> and behavior<sup>29</sup>. It is often necessary to settle these problems before the patients can be reintegrated into the community.

## PEDIATRIC REHABILITATION

Although there are similarities between programs for adults and for children, there are also marked differences, at all stages of the rehabilitation. The pediatric rehabilitation team must have pediatric specialization. The educational program must be started even as the patients are inpatients. There must be close coordination with the school system. These children often do not fit into the type of remediation class usually provided by the school system, and there must be close coordination between the family, the rehabilitation team and the teachers. Although excellent results often are obtained, we must be mindful of the fact that even mild head injuries can have permanent, devastating effects, particularly regarding behavior and cognition.

## PATIENT ADVOCACY

The National Head Injury Foundation (NHIF) is the chief advocacy organization in the United States for persons who have sustained brain injuries and for their families. Begun in 1980, the organization has 44 state

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## Cumberland Has Successful Experience Treating Head-Injuries

Cumberland is a JCAHO-accredited hospital, with eight years' experience treating patients with all levels of head injuries. This table shows the percentage of patients admitted to Cumberland at each RLA level during the past three years:

RLA Level 1	2.0%
RLA Level 2	45.0%
RLA Level 3	16.8%
RLA Level 4	15.7%
RLA Level 5	5.3%
RLA Level 6	5.2%
RLA Level 7	6.3%
RLA Level 8	3.2%

In addition, Cumberland has the experience treating young patients with many types of head injuries. This table shows the percentage of patients admitted with head injuries resulting from the following causes:

Automobile accident	44.0%
Pedestrian accident	15.2%
Bicycle accident	8.2%
ATV accident	5.3%
Skateboard	2.1%
All others	30.4%

## Cumberland's Staff

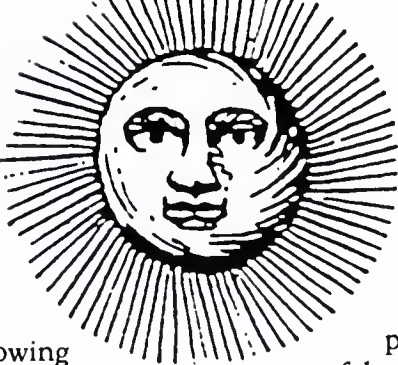
Because Cumberland is a hospital, and not just a rehab center, you can be confident that treatment is delivered by licensed rehabilitation professionals and other accredited hospital staff, all under the direction of an admitting physician. All physicians on Cumberland's admitting staff are board-certified in their specialty, and dedicated to the treatment of head-injured patients. The staff includes Donald A. Taylor, M.D., *Pediatric Neurologist*, Michael J. Decker, M.D., *Physiatrist*, Daniel N. Davidow, M.D., *Pediatrician*, and James E. Sellman, M.D., *Pediatric Psychiatrist*.

## Cumberland Hospital's Quiet Country Setting

Cumberland Hospital is located on a quiet, college-like campus that spans some 1,200 acres, just a few miles from Colonial Williamsburg and Jamestown. Healthy, outdoor activities—such as walking, hiking, and fishing—all available right here on the Cumberland campus are part of our comprehensive rehabilitation program.

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At dawn and dusk, deer can often be seen grazing at the edge of the woods around the hospital, and flocks of Canada geese stop by to feed and rest on their journeys North and South.



# Cumberland Patients Recover

Cumberland has a proven record of successful treatment and recovery with head-injured patients. In a recent study conducted jointly with the Medical College of Virginia Hospitals, of 36 patients at RLA 4 or below who were admitted to Cumberland within 180 days post-injury, 22 made substantial improvement of two or more levels on the RLA scale, while 9 of the remaining 14 patients improved by one RLA level. In the same study, it was noted that 10 of 16 patients admitted 180 days post-injury in a vegetative state improved by two or more levels on the RLA scale.

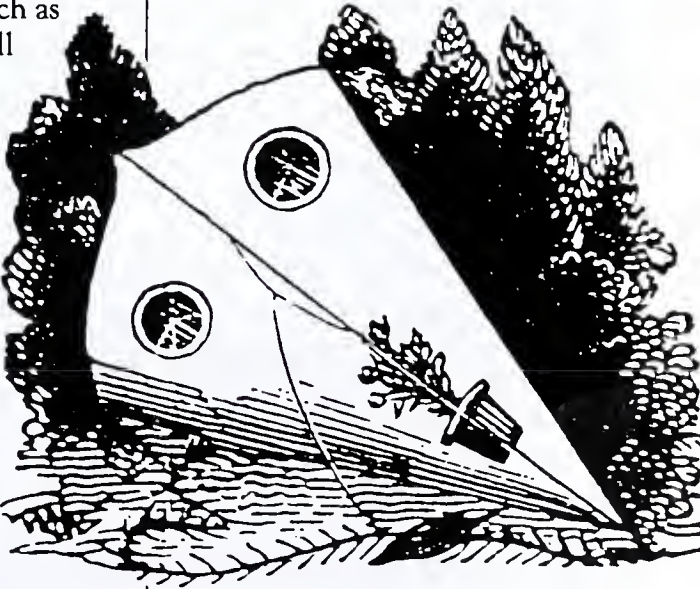
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chapters, 23,000 members and has made major progress in bringing to the attention of the federal government the needs of brain-injured Americans. Most notably, at the request of NHIF an Interagency Head Injury Task Force was established in 1988 by the Secretary of the Department of Health and Human Resources to identify gaps in research, training and service delivery and to recommend solutions to meeting the needs of persons with traumatic brain injury.

In Virginia, legislative efforts have been led by the Virginia Chapter of the National Head Injury Foundation, headquartered in Richmond. Begun in 1983, the Virginia Head Injury Foundation's first main achievement was the passage of the bill requiring hospitals and physicians to report all cases of head injuries that are likely to result in permanent disabilities. Since 1984, over 35,000 individuals have been reported. As a result of the formation of the Head Injury Council in 1985, the Head Injury Task Force Report serves to educate both policy makers and law makers.

Aside from a strong history of systems advocacy, the Virginia Head Injury Foundation serves as a clearinghouse for information on head injury for both lay persons and professionals and provides in-depth telephone assistance and outreach to all persons reported to the State Head Injury Registry. Project Head Coach, begun by the Foundation in 1989, offers peer support to families of patients in the acute stages of injury in preparation for the long rehabilitative journey ahead.

## OUTCOME

As a result of post-acute rehabilitation Burke et al<sup>24</sup> concluded that 70% of their adult patients were placed in less restrictive settings and over two-thirds were placed in productive employment; of the latter, 50% had maintained employment a year later. In the Glasgow experience of Brooks et al<sup>30</sup>, the employment rate before injury was 86% and after injury 29%; in Glasgow, however, there was no rehabilitation. The most careful studies to date are those of Cope et al<sup>4</sup> and Johnston et al.<sup>5</sup> Cope documents substantial improvements in function during post-acute rehabilitation, whether injuries were mild, moderate or severe, and persistence of these improvements without evidence of decrement. He also feels that despite the cost of the program, there is a definite potential for recouping these costs of the treatment in a reasonable length of time. He also concludes that the improvements are unlikely to be the result of spontaneous improvement alone. Johnston also concludes that improvements are the result of therapy but cannot find cost effectiveness. Cope and Johnston studied two different programs, probably with two different structures. However, both studies agree on the effectiveness of both programs in functional improvements.

## CONCLUSION

Traumatic brain injury is a devastating condition for the patient, family and community. Prevention is by far the most effective tool. Seat belts, air bags and enforcement of drunk-driving laws are measures that have shown beneficial results. An effective rescue squad and a neurosurgical team with a good protocol will minimize the damage. The continuum of rehabilitation programs needs to be well managed, so that patients enter a flow of appropriate programs. As a result of these efforts, we are seeing patients who formerly would have been entirely dependent now enjoying a good quality of life as productive members of the community. We also now know that as a result of these efforts, brain plasticity allows improvements to continue for years. We expect future basic, clinical and pharmacological research to achieve even better results.

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# First Single Lung Transplant in Virginia

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**L**UNG transplantation became a clinical reality in the early 1980s. The first established program in North America was at the Toronto General Hospital in association with the University of Toronto.<sup>1</sup> The ensuing decade has witnessed an evolution in techniques and approaches that have allowed several other centers to establish lung transplant programs in the United States. Much of the progress in this field has occurred in the laboratory. At the University of Virginia, a long-term commitment to lung transplantation in the laboratory has led to the establishment of a clinical transplantation program.<sup>2-7</sup> The first lung transplant performed at our institution is reported here.

## Case Report

A 57-year-old construction supervisor presented to the University of Virginia in 1989 complaining of progressive shortness of breath. A clinical diagnosis was made of interstitial fibrosis, and in October of 1989 he underwent open lung biopsy, which revealed the absence of normal alveoli and a honeycomb appearance to the lung tissue that was interpreted as being compatible with end-stage interstitial fibrosis. A CAT scan ordered because of an abnormality in the right lung on the plain chest film revealed a mass in the right lung. On operative resection of this mass, it was found to be atypical carcinoid with margins free of tumor.

His symptoms worsened and pulmonary function testing revealed an FVC of 3.8 liters/minute (78% predicted), an FEV<sub>1</sub> of 2.4 liters/minute (69% predicted), and a carbon monoxide diffusing capacity of 8.7 (21% predicted). Room air blood gases revealed a pH of 7.49, a PCO<sub>2</sub> of 32, and a PO<sub>2</sub> of 45. He was begun on home oxygen. Evaluation for the possibility of lung transplantation revealed no contraindication and on June 9, 1990, he underwent a left lung transplant. This lung transplant was carried out using the technique

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Presented at the annual meeting of the Virginia Surgical Society in Williamsburg on May 3, 1991.

developed by the Toronto Lung Transplant Program in which omentum was used to protect the bronchial anastomosis while it healed. He was treated with immunosuppressive therapy, which included cyclosporine and azathioprine. The patient was extubated within 36 hours of his transplant. He received corticosteroids in the immediate postoperative period for 1½ days. The bronchoscopy performed four days after his operation revealed a normal appearing anastomosis and no other remarkable findings. Daily oral steroids were added after the third postoperative week. He was discharged from the hospital three weeks after his operation. At discharge his pulmonary function tests were within normal limits and he no longer required any supplemental oxygen. Within three weeks of discharge he was able to go camping and hiking with his family.

Three months after the operation he developed some shortness of breath and bronchoscopy revealed a stricture at the site of the anastomosis. A silastic stent was fashioned from a tracheal prosthesis, and this stent was inserted in the operating room under general anesthesia through a rigid bronchoscope. Eleven months have elapsed since placement of this stent and the patient has remained asymptomatic.

## Discussion

This patient had the first successful single human lung transplant in the State of Virginia. Thus at the University of Virginia lung transplantation joins a program well established for cardiac, hepatic, renal, and pancreatic transplantation.

Transplantation of the lung has become more common in the United States in the past few years following the example of the University of Toronto. Actuarial survival for heart-lung transplant patients at Stanford has risen to 60% for three years. It appears that survival for single- and double-lung transplants is also in this range at several centers.<sup>8</sup> In addition to pulmonary fibrosis, which was the original condition for which lung transplantation was used, the conditions for which transplantation is an appropriate treatment have now expanded to include chronic obstructive pulmonary disease, emphysema, cystic fibrosis, pulmonary hypertension, and other incurable pulmonary conditions (Table 1).<sup>9</sup>

Patients referred for evaluation for lung transplantation must undergo extensive screening. If these are met, a more thorough evaluation is undertaken, often in the hospital (Tables 2 and 3).

The operative approach used in our first patient was developed by the University of Toronto<sup>10</sup> and variations have been introduced by others, primarily Trinkle and Grover at the University of Texas at San Antonio. Single-lung ventilation is employed. A posterolateral thoracotomy is performed for access to the chest while a small upper-midline abdominal incision is used to procure a tongue of omentum. The tongue is



**Table 1. Common Indications for Lung Transplantation.**

Idiopathic pulmonary fibrosis  
Chronic obstructive pulmonary disease  
Cystic fibrosis  
Alpha-1-antitrypsin deficiency  
Sarcoidosis  
Primary and secondary pulmonary hypertension

**Table 2. Screening Guidelines.**

Age less than 65  
Life expectancy 12-18 mons  
Relatively normal cardiac function  
Not on steroids  
Adequate nutritional status  
Able to walk 50-100 ft  
Psychologically stable and motivated  
Adequate social support system  
Must have stopped smoking  
No other organ failure

**Table 3. Inpatient Evaluation.**

Pulmonary: function tests, quantitative ventilation/perfusion scan; CT scan when indicated  
Cardiac: 2-D echo cardiogram, coronary angiography if over 30 yrs  
Psychological: indepth status assessment, social worker consult  
Musculoskeletal: exercise tolerance with oximetry (6-min walk)  
Nutritional assessment

tunneled substernally to allow it to be pulled into the chest later. The recipient's lung is removed, and the new lung is sewn into place. The pulmonary venous anastomosis is sewn first. This anastomosis is actually one in which a cuff of left atrium on the donor lung is sewn to the recipient's left atrium. The arterial anastomosis is performed next. The bronchial anastomosis is performed last. All anastomoses are performed using prolene suture. The bronchial anastomosis is then wrapped with the omentum, which is tunneled from the abdominal incision up into the chest. Chest tubes are inserted and the incisions closed. This technique was developed in the laboratory in Toronto to avoid complications with bronchial disruption resulting from the compromised blood supply to the ends of the bronchi. It was found that the bronchial wrapping technique almost completely prevented bronchial disruption in the laboratory.<sup>11</sup>

Strictures of the bronchial anastomoses have not been completely avoided even with the use of omentum. This complication is also thought to be the

consequence of ischemia in the area of the anastomosis. Stenoses have been successfully treated with dilatations, bronchoscopic debridement, and silastic stents as in our patient. Occasionally, operative resection has been employed successfully.<sup>12</sup>

**Summary**

Lung transplantation is now established as a clinical reality for patients with irreversible, lethal pulmonary conditions. We report the first successful application of this treatment modality in Virginia.

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# COMMUNICATING

## Listening

**A** RECENT article reported that the average physician interrupts his patient with a question 18 seconds after beginning a history. Moreover, the article continued, this is generally followed closely by a second question, so that the rest of the history is guided in a particular direction.

Communication is a recognized major problem in almost every human endeavor, but listening, which is half the process, has not received the attention it deserves. Actually, since we have two ears and only one mouth, listening ought to be two-thirds of the process.

Good listening is not a passive activity. It requires eye contact and attention. What is the accompanying body language? What is the tone of voice? Since speech is slower than thought, there is time to process the signals. Are you tuned in to the present conversation or has some distraction interfered with reception? We all tend to be more attentive to some speech (complimentary) and some people (attractive) than others.

Do we compensate for being tired, rushed, or distracted? And how do we know we received the correct message? Verifying the information by repeating the

words or summarizing the message insures proper transmission. It also tells the patient that you were listening and leads to a feeling of respect and trust, which improves the chances for first-class communication.

Obtaining a good history is taught as the foundation for competent medical care. The basic tool, listening, however, is not given the attention it deserves. Of course, the same principle of listening applies to all involved in patient care—colleagues, nurses, secretaries, lab workers.

Some of the physicians I know probably don't need more than 18 seconds to get to the heart of the matter when they see a new patient. If however, the physician invests the rest of the minute in checking for the elements of good listening, the investment will be worth it. One minute in the beginning may save many more later.

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## Touching

**'H**E NEVER even examined me!" How often I have heard that from a patient. On further questioning it is almost always untrue. What the patient really meant was that he or she was never touched except by a stethoscope or a reflex hammer. It is ironic that as we have added decades to life expectancy, essentially erased childhood infectious diseases and added enormously to the survival and well-being of our patients, they have appreciated us less and less. The reasons for this are many, but I do believe one factor is that we have transformed ourselves into the providers of technology rather than performing our traditional role as healers.

When we had limited resources for diagnosis (and treatment) available to us, a meticulous physical ex-

amination was necessary and that of course meant touching the patient. Now the technology is so superior that it appears to become far more important than what we can find with our fingers, and ears, and brains. Most of the non-medical specialties with whom I come in contact—nurses, physical and occupational therapists, myotherapists, chiropractors and osteopaths who still do manipulation—all do extensive "laying on of hands" in the course of their work. I believe this is one of the factors which spares them from the hostility reserved for physicians—although of course not the only factor.

In the course of a hospitalization of a patient, the least important thing for a physician to do on a particular day might be to examine the patient. Obtain-



ing lab results, talking to the radiologist, pathologist, physical therapist, etc. arranging for a consultation, discovering the patient's behavior and response to treatment with the nurses—all these may take precedence over examining of the patient. Yet to the patient the all-important event of the day is the physician's visit and in particular the physician's hands checking the pulse, examining the abdomen, etc. It takes very little time and effort, yet may bring a gratifying response.

A great deal of my practice involves soft tissue injuries. Many of these problems can be detected only with that extremely sensitive diagnostic tool, the fingers. It is not often understood that these problems are not trivial but may cause severe pain and disability even if they are not life-threatening. A recognition of these two facts—that these problems can only be detected by manual examination and that the pain caused may be very severe—has permitted me to help solve some perplexing problems. For example, a patient with severe pain in the upper back radiating through to her thorax had been hospitalized by a cardiologist who did a complete cardiac and pulmonary workup and concluded that there was nothing wrong with her thoracic viscera and sent her home, then was seen by a neurologist who did a thorough investigation of her spinal neuraxis as well as her upper GI tract, found nothing abnormal and discharged her, whereupon I saw her. Her story emphasized that the pain originated in the upper back and from there to the thorax and anterior chest. On palpation of the back there was exquisite tenderness which reproduced her pain. Local injection brought about significant reduction in pain and a brief further course of injections and therapy brought about its cessation. The comment of the patient was instructive. She stated that she had told each of the previous examining physicians where her pain was but none of them had touched her. They only ordered additional tests. Here was a very practical, not just psychological, reason for touching the patient, and one that is not uncommon.

We have serious problems in medicine today and touching the patient is not going to cure them. However it is an obvious way that we have to demonstrate our concern for their problems, to bond ourselves to them and to demonstrate that we are healers in the long tradition of medicine and not simply the appliers of modern technology and the dispensers of magical pills. Try it.

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## Use of Azathioprine in Nine Children with Crohn's Disease

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**I**N most cases, Crohn's disease and ulcerative colitis are treated with standard agents, which include symptomatic medications, sulfasalazine, steroids and antibiotics. Other supportive therapeutic modalities such as oral 5-ASA compounds, rectal 5-ASA and rectal steroids also may be used. When these standard and other usual supportive measures fail, immunosuppressive agents such as 6-mercaptopurine and azathioprine have been used. These compounds are considered adjuncts to therapy of inflammatory bowel disease (IBD) in adults,<sup>1-6</sup> but the experience with these drugs for treatment of IBD in pediatric patients is limited.<sup>7</sup> This report is not a randomized or controlled study but rather a pilot report of the usefulness of a potentially important treatment modality in complicated childhood inflammatory bowel disease.

### Materials and Methods

The IBD patients were selected from GI Clinic on the basis of treatment failure or the inability to reduce the dose of prednisone below 15 mg per day. The patients started on azathioprine were either (a) patients with chronic active disease and had failed to respond to sulfasalazine, steroids or metronidazole, (b) were receiving continuous steroids in doses over 15 mg daily for 6 months or more or developed toxicity to steroids, (c) had chronic fistulae and/or severe perianal disease, or (d) had been chronically active for many years.

Nine patients with active disease from 2 to 10 years (mean 4.8 years) entered the study. Three were males and six were females; age range 8½ years to 23 years (mean 17½ years). Two patients had ileocelectomy. All patients were on sulfasalazine and steroids at the beginning of the study. All the patients were steroid dependent and all of them developed Cushingoid features and acne.

*Azathioprine treatment.* Informed consent was taken from patients. Azathioprine was administered

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Submitted 12-4-90.

orally in the dose of 50 to 100 mg/day (1-2 mg/kg/day). Patients were continued on all pre-study medications. Steroid doses were adjusted according to routine indications. The bone marrow toxicity of azathioprine was monitored by complete blood count and differential and platelet count weekly for four weeks and then every month.<sup>8</sup> The hepatic toxicity was monitored by liver function test at the beginning and then every two months.

*Treatment goals and assessment of response.* The following clinical data were recorded at 3-month intervals: general well-being, weight gain, abdominal pain, fever, frequency and consistency of stools, rectal bleeding, arthritis, abdominal mass, activity of abscesses and fistula, signs of intestinal obstruction, Cushingoid features, hemoglobin levels and reduction in steroid doses. The degree of improvement or worsening was graded on a scale of 3+ for excellent improvement through 0 for no change to -3 for severe worsening. The amounts by which hematocrit levels increased were graded as: 0—no change, +1—5%, +2—10% and +3—15%. Reductions in the dose of steroid were similarly graded as: 0—no change, +1—25%, +2—50%, +3—>50% (Table 1).

Table 1. Grading of Clinical Data at 3 Months and 6 Months (\*) After Starting Azathioprine.

Variable	Patients								
	1	2	3	4	5	6	7	8	9
Well-being	+3 +3*	+3 +3*	+2	+3	+3	+3	+3	+3	+3
Symptoms & Signs	+3 +3*	+3 +3*	+2	+2	+3	+3	+3	+3	+3
Increased Hct	+3 +3*	0 0*	0	+1	+2	0	0	+3	0
Reduction in dose of steroid	+2 +2*	+1 +2*	0	+2	+3	+2	+3	+2	+1

Results

We have treated nine patients with Crohn's disease with azathioprine combined with prednisone, sulfasalazine and/or metronidazole; age range of 8.5 to 23 years (mean 17.5 years); for a period of 2 months to 28 months (mean 7.4 months). In one of nine patients (11%) there was only partial response with healing of the bowel disease (no rectal bleeding, no abdominal pain and decreased frequency of stools) but residual perianal abscess; nine of nine patients felt well within three months of starting azathioprine with weight gain in range of 0.5 to 5 kg (mean

1.5 kg). In all patients the abdominal signs and symptoms improved in three months. There were four patients with fistula and four patients with perianal disease. Two patients had both fistula and perianal disease. Of these, three of four (75%) fistula closed and three of four (75%) anal disease was healed. In eight of nine patients (89%) it was possible to decrease the dose of steroid by 25%. There is no toxicity of azathioprine reported to date in any of these patients.

Conclusions

Azathioprine is safe and effective as adjunctive therapy in children with complicated Crohn's disease, with a mean response time of three months. Acute toxicity to azathioprine is minimal and does not preclude its use in appropriate clinical settings. A study with a larger patient population and long term followup is needed to confirm these conclusions.

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# Alcohol Abuse Among College Freshmen in Greek Societies

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**M**OST would agree that alcohol abuse and addiction are major health problems. Few studies describe the drinking attitudes and practices of college students.<sup>1</sup> Berkowitz and Perkins<sup>2</sup> reviewed a decade of research on problem drinking among college students, but they did not relate drinking patterns to Greek societies.

To better understand how drinking patterns relate to plans of first-year college students to join fraternities and sororities, we surveyed about 2,000 first-year students at the University of Virginia in September 1988, one month after their arrival in Charlottesville. We focused on drinking patterns by sex and social preferences.

## Materials and Methods

The study population was 2,626 first-year students (1,316 men and 1,310 women) at the University of

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Supported in part by U.S. Department of Education grant No. G008730492-87.

Submitted 8-28-90.

Virginia. After one month of college, we gave all subjects a questionnaire to quantify drinking patterns during the prior two-week period. We asked students not to identify themselves to ensure confidentiality and increase the likelihood of an accurate survey.

Students returned 2,081 questionnaires (79.2%). Following checks for internal consistency, we selected 1,929 questionnaires (73.5% of all students and 92.7% of returned questionnaires). These 1,929 questionnaires form the basis for our study. Data analyzed derive from eight of the questions on the questionnaire.

We defined a drink as: 1) 12-oz. can or bottle of beer, 2) 4-oz. glass of wine, 3) mixed drink or shot glass of liquor, or 4) 12-oz. bottle of wine cooler. We defined frequent heavy drinkers as those students who consumed five or more drinks on at least one occasion each week.<sup>3</sup> A drinking index was derived (Table 1).

In statistical analysis, we used unpaired, two-tailed, *t*-statistic and Chi-square testing. The Bonferroni principle of multiple comparisons (dividing the significance level of .05 by the number of tests done) was used. This gives a significance level of .0125 (.05/4) for our four Chi-square tests.

For illustrative purposes (Table 1), we combined male and female students. We calculated a drinking index for each level of drinking (number of drinks in a row). We multiplied the number of students by the drinking occasions (0 for no occasions, 1.5 for 1-2 occasions, four for 3-5 occasions, and eight for 6 or more occasions) and summed the result at each level (5 or more drinks, only 3-4 drinks, only 2 drinks, and only 1 drink) to get drinking indices for each level (sum of students  $\times$  occasions). The following example using data from Table 1 explains how we calculated a drinking index. The drinking index of the row of 5 or more drinks for each occasion among students planning to join a Greek society was  $(251 \times 1.5) + (216 \times 4) + (174 \times 8) = 2633$ . This value (2633) appears in the first column of Figure 1. Using drinking indices in a  $4 \times 2$  contingency table revealed there was more drinking among those planning to join Greek societies than among those not planning to join (Chi-square = 119.4 with three degrees of freedom,  $p < .0001$ ) (Fig. 1).

## Results

Almost every student was between their 17th and 19th year (884 men: 17.84 SD .50 years, 1045 women:

Table 1. Drinking Indexes Derived From Survey of 2,626 First-Year Students at the University of Virginia.

Number of drinks	Students planning to join Greek society (Base of 1000)					Students not planning to join Greek society (Base of 1000)				
	Occasions over two weeks				Drinking Index	Occasions over two weeks				Drinking Index
	0	1-2	3-5	6 or more		0	1-2	3-5	6 or more	
5 or more	359	251	216	174	2633	607	222	117	55	1241
3-4	320	457	155	67	1842	530	350	96	24	1101
2	379	456	115	50	1544	526	379	70	25	1049
1	399	451	97	53	1489	463	426	79	32	1211

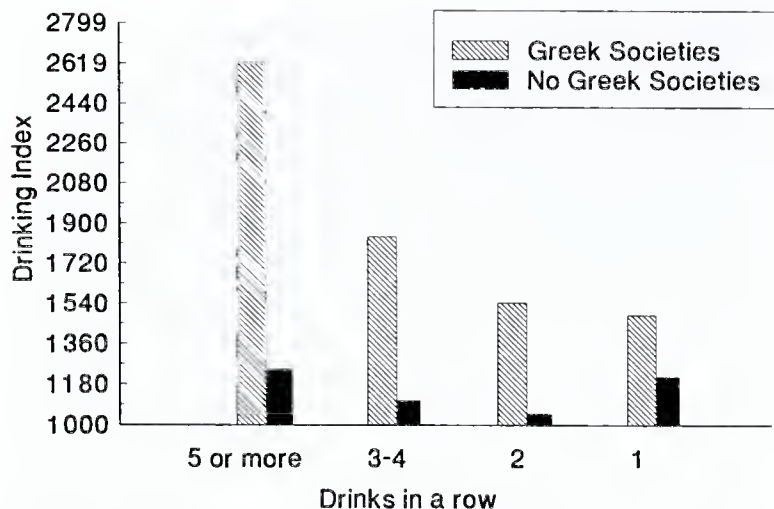


Fig. 1. Combined patterns of drinking for male and female students during the two weeks prior to answering the questionnaire.

17.74 SD .52 years,  $t = 3.970$ ,  $p < .0001$ ), single, and living in a dormitory. Four-fifths of students were white and one-ninth were black. Four out of ten planned to join a Greek Society. One student in nine (10.7 percent) denied ever having used alcohol. In our remaining findings, we excluded students from analysis who had never used alcohol.

Men planning to join a fraternity drank more heavily than those not planning to join (drinking indices in a  $4 \times 2$  contingency table, Chi-square = 95.7 with three degrees of freedom,  $p < .0001$ ). Similarly, women planning to join a society drank more heavily than those not planning to join (drinking indices in a  $4 \times 2$  contingency table, Chi-square = 56.5 with three degrees of freedom,  $p < .0001$ ).

We derived drinking indices to test whether there was a difference in patterns of drinking by sex. Using drinking indices in a  $4 \times 2$  contingency table revealed there was more drinking among men than among women (Chi-square = 408.6 with three degrees of freedom,  $p < .0001$ ). These differences were greatest at higher levels of alcohol consumption.

Half of the men and a quarter of the women in our study were frequent heavy drinkers.<sup>3</sup> When we looked at men planning to join a fraternity, 70% of them were frequent heavy drinkers. Of men not planning to join a fraternity, 40% were frequent heavy drinkers. One-third of women planning to join a sorority were frequent heavy drinkers and 15% of women not planning to join were frequent heavy drinkers.

## Discussion

Our findings derive from a self-reporting questionnaire, not from observed drinking patterns. There are inherent limitations in this approach because student responses may be conditioned by such factors as need for approval. We emphasized anonymity and hoped that this would protect against biased reporting.

Eighty-nine percent of our students had drunk alcohol at some time during their lives. This is consistent with the findings of other investigators.<sup>4-6</sup> When we

separated drinking by sex, we found that male college students drank more than their female counterparts. Recent evidence suggests that women are more vulnerable than men to the effects of alcohol consumption because they have less gastric alcohol dehydrogenase activity than men.<sup>7</sup> Diminished gastric enzyme activity leads to decreased gastric oxidation of ethanol and this leads to higher levels of blood alcohol (and, presumably, brain alcohol). This increased vulnerability to the effects of alcohol may account for the lower alcohol consumption by women in the series.

In 1979, Wechsler and McFadden<sup>5</sup> surveyed more than 7,000 college students from the Northeast states. They found that 29% of men and 11% of women met Blane's criteria of frequent heavy drinking.<sup>2</sup> A recent survey of high school seniors showed that half the men and a quarter of the women drank five or more drinks in a row in a two-week period.<sup>8</sup> As a group, our students drank more than students reported by Wechsler and McFadden<sup>5</sup> and the same amount as the students reported by Johnston et al.<sup>8</sup>

Disproportionately, those planning to join Greek societies were frequent heavy drinkers. We do not know why our frequent heavy drinkers seek Greek societies. A more detailed study is needed to determine if Greek societies foster heavy drinking or attract heavy drinkers.

The authors thank Sara Wilson and Cary Osborne for help in the manuscript preparation.

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# Role of Colonoscopy in Treatment of Colorectal Carcinoma

Luiz E.G. Mineiro, MD,  
*Clifton Forge, Virginia*

**T**HE treatment of carcinoma of the colon and rectum is complicated by a large incidence of synchronous (lesions occurring at same time as index cancer) lesions reportedly varying from as much as 1% to 8% for carcinomas and from 9% to 55% for polyps.<sup>1-10</sup> The knowledge of the location and nature of these lesions is essential for the proper planning of the treatment of the index cancer.

A search for the ideal way of evaluating the patient's colon before or soon after resection for carcinoma is still going on. Since the beginning of modern abdominal surgery a hundred years ago, physical examination, rigid sigmoidoscopy, full column air contrast barium enemas have been successively added to the surgeon's armamentaria. The latest entry is colonoscopy, made popular in the 1970s.<sup>11</sup> It is superior to other methods because it provides information about the nature, location and number of synchronous lesions which might alter the original plan of treatment. Furthermore, the endoscopic removal of polyps, if one concurs with the polyp-cancer sequence theory, can aid in the prevention of subsequent cancer. The reservations for using colonoscopy are raised by some authorities on the basis of cost of the procedure,<sup>12</sup> limited availability, and the theoretical possibility of either implantation or dissemination of malignant cells by the instrument as it passes over the cancerous lesion.<sup>13</sup> My experience so far indicates that most of these reservations are unfounded. The present cost of colonoscopy is reasonable, considering that the procedure is therapeutic as well as diagnostic in most cases. Availability has become almost universal; the experience in our small hospital is a case in point. As to the last objection, at least from my experience, no unexpected increase in tumor implantation and/or dissemination has been found.

## Methodology

One hundred sixty-seven patients with carcinoma of the colon were selected from a total of 2,412 consecutive cases that underwent colonoscopy performed by the author from March 12, 1974 to July 14, 1988, at

Presented at the annual meeting of the Virginia Surgical Society on May 3, 1990, at the Homestead in Hot Springs. Address correspondence to Dr. Mineiro at PO Box 531, Clifton Forge VA 24422.

Alleghany Regional Hospital, a 160-bed rural facility. The indications for colonoscopy in this group of patients were one or both of the following: 1) A high probability of cancer on the basis of either physical examination or x-ray studies. 2) Guaiac+ stool.

All the patients with cancer of the colon were examined the day before their colectomy. The day before the colonoscopy, all patients received a bowel preparation consisting of a clear liquid diet and saline cathartic (Evac-q-kit®). On the morning of the procedure, the patients received orally a balanced electrolyte solution with polyethylene glycol or a solution of Manitol 10% USP. The colonoscopy was usually performed during the morning hours. If the presence of carcinoma was confirmed, the patient received erythromycin 1 gram and neomycin sulphate 1 gram PO at 13:00, 14:00, and 23:00 hours and was operated upon the following morning. Synchronous lesions were either removed or biopsied, and the extent of the operation was planned as a result of the pathology report on these lesions. If the colonoscope could not be advanced into the patient's cecum (or to the end of the remaining colon), the examination was repeated within four months of the operation.

All colonoscopies were done under titrated intravenous sedation with meperidine hydrochloride and either diazepam or midazolam hydrochloride. Since 1988, patients' vital signs and oxygen saturation have been monitored during the procedure.

These patients were all followed for at least one year.

## Results

All colonoscopies performed on this group of 167 patients were completed without complications. In 46 cases (27.5%), the scope failed to be advanced into the cecum. Either obstruction due to the carcinoma or previous right colectomy was the reason for failure in 35 (20.9%). Technical difficulties account for the remaining 11 (6.5%) of the patients. The percentage of patients in whom the cecum was reached by the scope, currently at about 98%, has increased with the growing experience of the author.

Twenty-five patients with carcinoma (14.9%) had synchronous polyps; 15 (8.9%) had metachronous (lesions occurring after discovery of the index cancer) polyps; 5 (2.9%) had synchronous carcinoma; and 14 (8.3%) had metachronous carcinoma.

One patient had a polyp which contained carcinoma in situ. The maximum number of polyps removed from a single individual was four. Of the 30 patients with synchronous lesions, 13 were followed for one year only, either because the patient died or was lost to followup. The other 17 were followed with yearly colonoscopy from 2 to 10 years. None of these patients developed metachronous carcinomas; however, one patient did develop metachronous polyps. Conversely,

all the patients that developed metachronous cancer did not have previous polyps. Five of the carcinomas were recurrences of the index primary cancer. All five were located in the rectum and occurred within three years of the index primary tumor. Of the nine true metachronous tumors, two occurred within one year of the original treatment. Neither of these two had preoperative colonoscopy. The other seven occurred from 2 to 13 years following the index primary cancer. Of these seven patients, five did not have synchronous polyps at the time of the original operation. The other two had the original operation elsewhere and this information was not available.

The diagnosis in five patients was changed from cancer to a non-malignancy after the colonoscopy. The extent of the operation in three patients was modified because of preoperative colonoscopic findings.

### Discussion

Although based on a relatively small sample, my data agree in most cases with published literature on the subject. The incidence of metachronous lesions found is within range of findings reported in the literature. Published data indicate that the incidence of metachronous lesions is from 13% to 62% for polyps and 2% to 9.2% for cancers<sup>3,10,14-16</sup>. All five recurrent carcinomas occurred within three years of the index primary tumor, also in agreement with the published data.<sup>17</sup>

There is one discrepancy between my data and the published literature which I cannot explain. It is the absence of polyps preceding all metachronous cancers in my series. I am continuing to collect information on this matter and plan to review it in the future.

During the time span comprising this study, a number of improvements in the technique of the procedure, such as newer instrumentation, better bowel preparation, and safer intravenous sedation, have enhanced its sensitivity and specificity. It should be emphasized that colonoscopy still remains an operator-dependent procedure with a definite learning curve associated with its use.

In conclusion, I am convinced that colonoscopy is superior to any other method of preoperative evaluation of patients with cancer of the colon. It should be part of the skills of any surgeon who treats colorectal malignancies; regardless of the size and sophistication of his/her working environment.

The author gratefully acknowledges the contributions to this article of his wife, Barbara E. Mineiro, MSLS, who created and maintained the computerized database.

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# ABSTRACTS

*These are abstracts of papers presented at the annual meeting of the Virginia Society of Otolaryngology/Head and Neck Surgery held May 17-18 in Norfolk. Dr. R. Jack Eastham was program chairman.*

**Facial Nerve Monitoring During Parotidectomy.** Scott Morin, MD, Michael F. Pratt, MD, and Richard L. Prass, MD, Norfolk.

Facial nerve preservation is mandatory in surgery of the parotid gland for benign and selected malignant diseases. Minimizing manipulation and trauma to the nerve rami improves the changes of normal postoperative facial nerve function. We present our early experience using a four-channel facial nerve monitor during parotidectomy. We find that monitoring provides information in identifying nerve tracts and detection of nerve trauma. A brief videotape depicts highlights of the type of feedback available to the operating surgeon.

**Facial Nerve Neuromas.** David Oliver, MD, Aristides Sismanis, MD, and George H. Williams, MD, Richmond.

To illustrate the diagnostic and management problems of facial nerve neuromas, we present three representative cases. Progressive facial paralysis, hearing loss, vertigo, tinnitus, and mass in the ear canal or parotid gland are presenting symptoms and signs. Treatment consists of resection of the lesion and appropriate repair of the facial nerve. The workup and management of these patients is presented in detail. A short video movie of the removal of facial neuroma is presented also.

**Vagal Paragangliomas: Cranial Nerve Impairment and Selection of Therapy.** H. Alexander Arts, MD, and Paul A. Fagan, MD, Charlottesville.

Six cases of vagal body tumor are reviewed. All cases presented initially as painless neck masses with normal cranial nerve function. Otologic symptoms were infrequent, occurring only with temporal bone involvement. In true vagal paragangliomas, cranial nerve and auditory function is usually preserved until there is extensive skull base disease. Tumor progression following radiotherapy was documented in four cases, three of which were treated to 4500 cGy or over. One case was found to have regional lymph node metastases. The six patients had a total of ten head and neck paragangliomas, illustrating the high incidence of synchronous and metachronous lesions. Due to the high incidence of multiple lesions, these tumors threaten lower cranial nerves bilaterally in many cases. Because cranial nerve function is preserved until late, and because vagal and accessory nerve paralysis is usually unavoidable with resection, we

advocate conservative treatment in selected cases. Surgery may be reasonably postponed until cranial nerve impairment becomes evident or other vital structures are threatened.

**Approach to the Patient with Olfactory Dysfunction.** Pamela Crawford, MD, and Gary L. Schechter, MD, Norfolk.

A brief preview of anatomy and physiology precedes categorization of etiologies of anosmia, directing the approach to the affected patient. Current methods of testing, indications for radiographic studies and treatment modalities are presented.

**Melkerson-Rosenthal Syndrome: Report of Two Cases and Review of the Literature.** Steven Mucci, MD, and Aristides Sismanis, MD, Richmond.

Melkerson-Rosenthal syndrome is a rare clinical entity of unknown etiology which in its classic form presents as a triad of recurrent unilateral facial or lip edema, fissured tongue and recurrent facial nerve weakness or paralysis. We discuss two cases which illustrate the diverse presentations one can encounter in clinical practice. The first case involves recurrent facial nerve paralysis in a child treated with surgical decompression on opposite sides nine years apart. The second case involves a bizarre presentation of bilateral facial nerve paralysis with fissure tongue in a young adult.

**Water Precautions in Children with Tympanostomy Tubes.** Michael Shroyer, MD, Craig S Derkay, MD, and Jeffrey Ashby, BS, Norfolk.

A total of 1,393 board-certified otolaryngologists (mean = 15.1 practice years) returned a survey sanctioned by the American Association of Otolaryngology/Head and Neck Surgery regarding the use of water precautions in the prevention of otorrhea in children after tympanostomy tube placement. Of those surveyed, 17.6% forbid children with tympanostomy tubes from swimming; 83.4% allow water exposure but only 2.6% allowed this exposure without limitations or precautions. Limitations on the depth of swimming were placed by 71% and limitations on the type of swimming water by 25%. Recommended precautions included ear plugs only (54.8%), bathing cap and ear plugs (25.2%), ear plugs or cap and antibiotic drops (13.1%), antibiotic drops only (3.5%), and bathing cap only (2.1%).

The full survey results, its implications and the



preliminary findings from our prospective clinical trial are presented.

**Functional Endoscopic Sinus Surgery.** Michael Stamm, MD, and Aristides Sismanis, MD, Richmond.

In this communication we present our experience with functional endoscopic sinus surgery (FESS), a technique pioneered in Europe by Messerklinger, Stammberger and Wigand and in the United States by Kennedy. In 70 patients operated on during the past 2 years, control of the disease was achieved in approximately 85% of these patients and the complication rate was less than 1%. We have found this technique very successful and we strongly recommend it to others.

**Resection of Sphenoid Encephalocele Using the Rigid Nasal Endoscopes.** Brian D. Deutsch, MD, and Charles W. Gross, MD, Charlottesville.

Rigid nasal endoscopes have become increasingly popular for treatment of both acute and chronic sinus disease. They allow direct visualization of the osteomeatal complex and facilitate resection of diseased tissue in this region. More recently, they have been used in the operative treatment of intranasal and sinus conditions other than sinusitis, including repair of cerebrospinal fluid leaks (from trauma or previous

surgery) and biopsy and/or resection of intrasinus lesions. A case is presented describing the use of the endoscopes and associated instruments for resection of a relatively unusual lesion, an intra-sphenoid encephalocele. A brief discussion of cephaloceles and suggestions for the use of endoscopic surgery in their management follows.

**Evaluation of Head and Neck Structures Using MRI.** Premal Khetia, MD, Gary L. Schechter, MD, and Michael F. Pratt, MD, Norfolk.

Although the diagnosis of a head and neck neoplasm is usually based on examination of mucosal surfaces, CT is often employed to delineate the deep extent of pathology. MRI has been found to provide greater discrimination among soft tissue interfaces. It displays extent of pathology more accurately than CT in areas without bony involvement.

This presentation outlines the indications for the use of MRI in evaluating head and neck disease and includes a detailed discussion of normal morphology.

**Temporalis Myofascial Flap in Head and Neck Reconstruction.** James F. Reibel, MD, Richard Scher, MD, and Paul A. Levine, MD, Charlottesville.

In performing resection of head and neck malignancies, a defect is sometimes created that proves to be a

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surgical dilemma, since it is too large to close by mobilization of adjacent tissue or too small to necessitate the development of a large distant flap for closure. In the past year, we have found that defects of the lateral oropharynx, the lateral skull base, and the orbitomaxillary region fit these criteria, and we have utilized the temporalis myofascial flap, sometimes including pericranium, to close these defects in nine patients. The discussion will include the protection of the branches of the deep temporal artery, avoidance of injury to the frontalis branch of the facial nerve, wound complication, flap limitations, and cosmetic deformities associated with the flap.

**Takayasu's Arteritis of the Neck: A Case Study and Review of the Literature.** Tab E. Thompson, MD, William Slomka, MD, and Aristides Sismanis, MD, Richmond.

Takayasu's arteritis is an inflammatory disease involving the intima, media and adventitia of large vessels with a predilection for the aorta. The disease is characterized by the absence of pulses of the affected vessels. Involvement of the neck is very uncommon with this disease. We present a case of a 32-year-old caucasian female with a left-sided Horner's syndrome and a neck mass. Following computed tomography of the neck and angiographic studies, open biopsy re-

vealed findings consistent with Takayasu's arteritis. Presentation, diagnosis and management of this unusual disease are discussed in detail.

**Prospective Management of Bleeding Dyscrasias in Children Undergoing Otolaryngic Surgery.** Eric Plotnick, MD, Craig S. Derkay, MD, and Eric Werner, MD, Norfolk.

Peri- and post-operative hemorrhage is always of concern. Children with known bleeding dyscrasias such as von Willebrand's disease and hemophilia present additional challenges. Over the past 2 years, we have performed adenotonsillar and middle-ear surgery on 10 children identified as having either von Willebrand's or hemophilia. These patients were prospectively managed, in conjunction with the pediatric hematologists, using either DDAVP (desmopressin) or Factor VIII cryoprecipitate. Uneventful courses were observed for all patients save one who developed a post-tonsillectomy bleed on day 12 in the presence of normal coagulation studies. A review of the current literature regarding the use of DDAVP and Factor VIII is presented as well as our treatment algorithm for managing these challenging cases.

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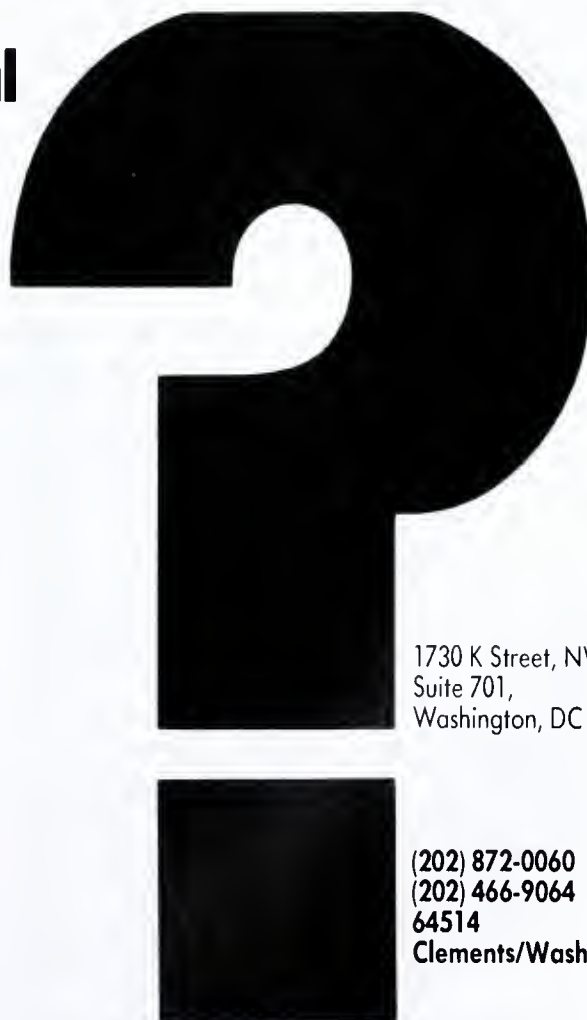
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# Physician's Guide to the Natural Death Act

From the time it became effective in 1983, the Natural Death Act (now codified as Virginia Code §54-2981 et seq) has been subject to amendment by the General Assembly. The amendments passed in 1991 deal with significant changes in the definitions of "terminal condition" and "life-prolonging procedure." They also offer the declarant the option of requesting the provision of any specific procedure or treatment. The passages reflecting these amendments appear below in italics; they apply to all declarations, regardless of when they were made.

The Act now defines a "terminal condition" as any condition "caused by injury, disease or illness from which, to a reasonable degree of medical *probability*, (i) there can be no recovery and (ii) death is imminent. *The term also means a persistent vegetative state, in which a qualified patient has suffered a loss of consciousness, with no behavioral evidence of self-awareness or awareness of surroundings in a learned manner, other than reflex activity of muscles and nerves for low level conditioned response, and from which, to a reasonable degree of medical probability, there can be no recovery.*"

"Life-prolonging procedure" was redefined by the legislators to include hydration and nutrition, as follows: ". . . any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. *The term includes hydration and nutrition.* However, nothing in this act shall prohibit the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain."

These are the steps the law requires:

1. A patient makes a declaration directing the withholding or withdrawing of life-prolonging procedures in the event of a terminal condition. As a result of a third 1991 amendment, *the suggested form of declaration includes an optional statement directing any specific procedure or treatment to be provided, such as hydration and nutrition.*

If the declaration is written, it must be signed by the patient and two witnesses, neither of whom may be the patient's spouse or blood relative but one of which may be the physician.

If the declaration is oral, it is valid only (i) if made after the patient has been diagnosed as having a terminal condition and (ii) if it is made in the presence of a physician and two witnesses, neither of whom may be the patient's spouse or blood relative.

2. If the patient has made a valid declaration and is competent, the attending physician must then certify

in writing that the patient has a terminal condition before withholding or withdrawing a life-prolonging procedure.

3. If the patient has made a valid declaration but is "comatose, incompetent, or otherwise physically or mentally incapable of communication," the attending physician must certify in writing that the patient has a terminal condition and must also have one other physician examine the patient and do likewise before withholding or withdrawing a life-prolonging procedure.

4. In the case of a patient who is comatose, incompetent or otherwise physically or mentally incapable of communication and who has not made a written or oral declaration, the Act designates these persons, listed in order of priority, with whom the attending physician must consult and agree prior to withholding or withdrawing a life-prolonging procedure:

1) any guardian or committee judicially appointed on behalf of the patient;

2) anyone designated in writing by the patient to make the treatment decision;

3) the patient's spouse;

4) an adult child of the patient or a majority of the children who are reasonably available for consultation;

5) the parents of the patient;

6) the nearest living relative of the patient.

If no one in the first category is "reasonably available, willing and competent to act," the physician may go to the next priority, and then the next, until an appropriate person is located.

But when the physician must turn to any of the family members in the last four categories, the physician (i) must insure that there are two witnesses present when the treatment decision is made with those family members, and the patient's spouse and blood relatives may not serve as either of these witnesses, and (ii) must get consent from two persons in any of the last four categories if two are reasonably available.

Two points should be emphasized. First, the Act does not apply to patients who are under 18 years of age. Second, if a physician does not want to direct the withholding or withdrawing of life-prolonging procedures as authorized by this Act, he has no obligation to do so; he must, however, offer to transfer the patient to another physician.

The Act does not eliminate any immunity a physician already may have under the common law.

*Attorneys Sandra Kramer and Allen C. Goolsby III developed this legal information for the June 1983 issue of VIRGINIA MEDICAL. This version, prepared to include the amendments to the Act passed by the 1991 General Assembly, also includes all prior amendments to the original Act.*

7/1/91



Priority Goes to Durable Power Agent

Broader Surrogate Scope Affects Old, New Declarations

Mindful that Missouri's Cruzan case could happen in Virginia, the 1991 General Assembly broadened the powers of Virginia's Natural Death Act with amendments that add a hydration and nutrition clause and expand the definitions of "terminal condition" and "life-prolonging procedure." The amending language appears in italics on the opposite page, in VMQ's revised Physician Guidelines. The changes became effective on the first day of this month of July. They apply to all declarations, regardless of when made.

Previously, the definition of "terminal condition" called for "a reasonable degree of medical certainty." Now, you will note, the phrase is "a reasonable degree of medical probability." Note also the addition to terminal condition of "persistent vegetative state" and its detailed definition.

The "life-prolonging procedure" definition now encompasses *hydration and nutrition*, thus obviating what has been a sticking point for those involved in these cases.

Declarants who want to specify that hydration and nutrition be made available to them can now exercise an *optional statement* directing that this or any other procedure or treatment be provided.

The declaration form the QUARTERLY offers to physicians and lay persons has been revised to reflect all these changes. Reassure your patients who have signed the old forms, however, that the changes apply to their declarations.

The amendments occasioned no changes in the durable power of attorney for health care form itself but made this important change in its powers: *the person holding the durable power now has the highest*

*priority in terms of authorization to provide consent.*

Both forms are offered to you free of charge. Both may be photocopied at will to give to your patients. It should be noted, however, that some attorneys believe the more complex durable power document should be prepared individually by counsel.

Both forms are cognizant of Virginia law; they may not be viable in another state. The Natural Death Act form requires witnessing by two persons who are neither spouse nor blood relative of the signator. The durable power document asks for a notary seal; most banks provide notarization to their customers free of charge.

The original instrument should be kept in an accessible place—not a safety deposit box. The signator should also carry a wallet card indicating the existence of a surrogate decision-making instrument. Copies should be given to 1) close relatives of the signator; 2) the signator's treating physician; and 3) any person

designated to make decisions.

The Natural Death Act form is valid until revoked, and unless limited to a specific time period by the document itself, so too are the durable powers. Either form can be revoked, but attorneys suggest that the revocation be in writing, in the manner of the original document, and that it be notarized. If the signator wants to designate a different surrogate or specify different treatment choices, the original document should be revoked and a new instrument written, signed, witnessed and notarized.

It is incumbent upon the treating physician to retain the document in the patient's medical record. Indeed, many physicians have begun routinely educating their patients to these documents and encouraging their use. Such action will prove helpful to all concerned when the new federal law tying living wills to hospital admissions goes into effect January 1, 1992. —A.G.

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# VIRGINIA MEDICAL JOURNAL

## More about Health Care

**A**s an earlier editorial has commented,<sup>1</sup> unless the insurance industry, with the help of the medical profession, solves the problem of access to health care, national health insurance is sure to come. Inference might be drawn that only the poor and underprivileged are so affected. It seems that problems may exist even for those able to pay.

Health care in the United States now is largely controlled by government programs such as Medicaid and Medicare, and by programs initiated and managed by insurance companies, in collaboration with big business. The laudable goal was/is twofold: good health care at an affordable price (after all, health care in the United States is now more than 11% GNP). Neither objective has been attained. The cost of medical care continues spiralling upward; access to

medical care is still a problem. Why?

The answer is simple; the remedy is not. After all, physicians are notoriously poor money managers; the answer: make medical care a business and let business people manage it. The insurance companies, in conjunction with big business, set about doing just that. Unfortunately, the bottom line got in the way. These money managers found they were able to manage health care more economically and even turn a profit. So business has provided jobs for many and profit for a few, but health care in the United States is neither improved nor more accessible. Further, the cost continues upward.

E.L.K., JR.

1. ELK jr. Our health care system. VMQ 1991;118:117-8

## Both of Us

**Y**OU would not call her pretty nor him handsome, but I am sure they were in their day. Now they were a loving elderly couple, still mentally vigorous although physically frail after 60 years of married life together. Of modest means, they were proudly independent and had lived in their own rural home for 50 years.

When she came for a followup examination of her glaucoma and cataracts, she looked alarmingly frail and tired. Concerned, I inquired about her general health and about her husband. Her health was doing all

right, she said, but then she sighed and told me that he had recently had pneumonia. She had nursed him at home, and it had been a difficult time for both of them. She was very tired but very happy that he was now recovering.

Obviously contemplating, she was quiet for a moment and then added, "Doctor, it's just all that the two of us can do to take care of the two of us."

I have never heard it better said.

H. S. CAMPBELL, MD

## Want to Practice Medicine?

**I**T SEEMS that everybody wants to practice medicine without the necessity of going to medical school. Pharmacists and nurse practitioners want to prescribe;

nurse midwives practice uncomplicated obstetrics and would like to expand their horizon; optometrists want to diagnose and treat diseases of the eye; podiatrists



would like to be general surgeons in the area of the lower extremities (first the feet, now further and further upward toward the knee); physiotherapists push for independent practice; and the list goes on.

Are they right? It hardly seems likely. Medicine has become and is becoming increasingly complicated. It would be gross malpractice for the writer, a pediatrician, to electively undertake the management of an adult with coronary heart disease. He is not trained to do so.

The management of routine and minor illness is not difficult and may be easily learned. The problem lies in the need for knowledge and judgment in recognizing the presence of serious illness masked as a minor disability. The store of medical knowledge is so great and so complex that it is impossible for a physician to be knowledgeable in all areas, but judgment made possible by education and training is essential.

If, then, the physician, with eleven to eighteen years of schooling (college, medical school, residency training), is unable to effectively screen, diagnose, and manage patient care in all areas, it seems unlikely that

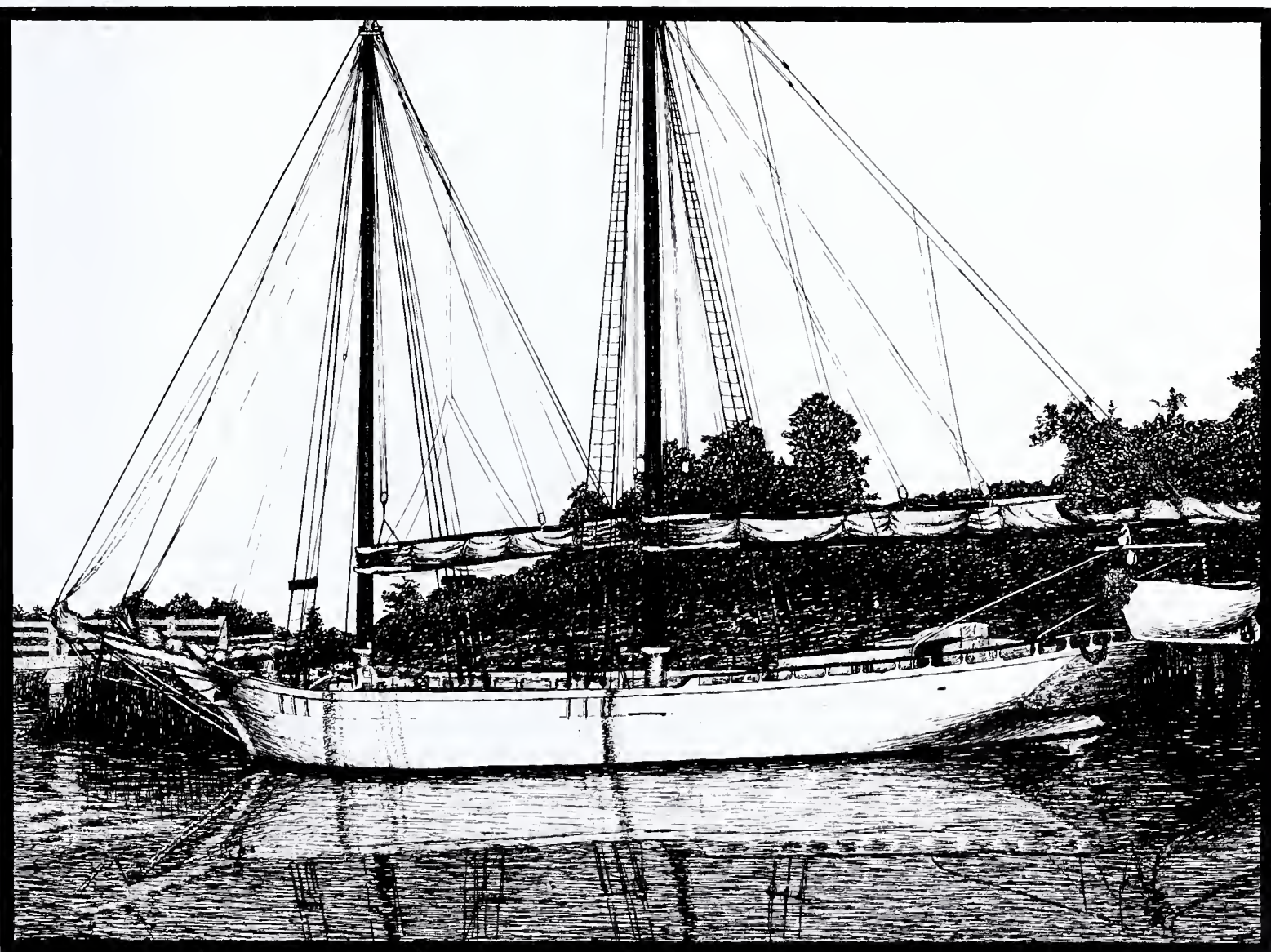
such can be accomplished by one who has not had such education and experience. Nurse practitioners, supervised by a physician, perform well. The same is true of physiotherapists and most of the others. Judgment is essential. Let us not close the medical schools.

E.L.K., JR.

## All for One

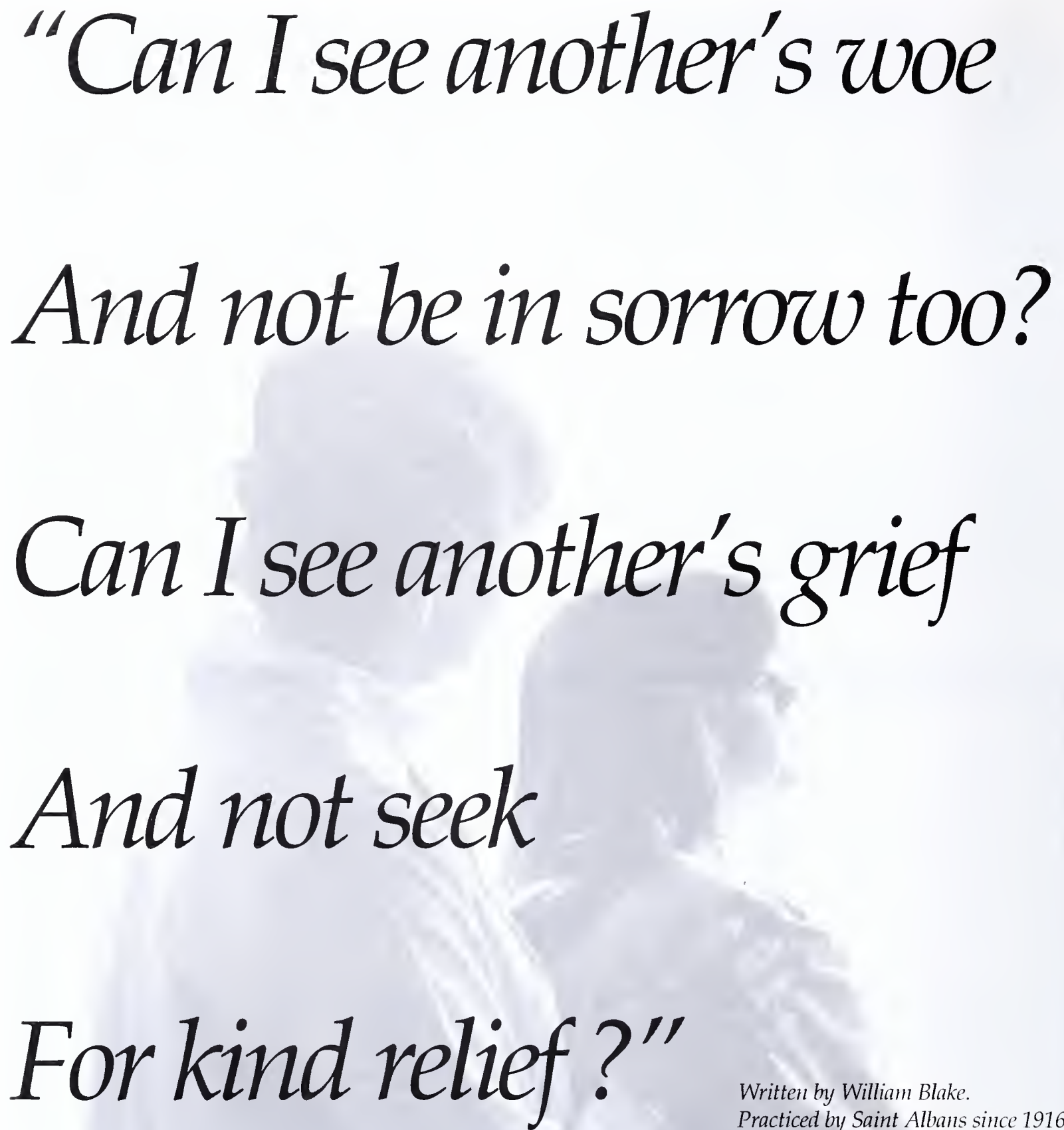
THE reader is referred to Dr. John Daniel's Letter to the Editor on page 139. It may seem to some of you that this is the same tired old theme, applied to the same old problem of governmental meddling in medical affairs. It is more than that. It is a plea for the medical profession to stand together. That we have in the past not been united is painfully clear and the results have been disastrous. We must present a united front; a negative attitude by some and support by others will not do the trick.

E.L.K., JR.



*Columbia F.C.*

A. L. VAN NAME, JR., MD




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And not be in sorrow too?  
Can I see another’s grief  
And not seek  
For kind relief?”*

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# VIRGINIA MEDICAL OBITUARY

• **Thomas Grasty Bell, MD**, Staunton obstetrician/gynecologist; University of Virginia School of Medicine, 1943; age 71; died April 29, 1991.

• **Leon Irving Block, MD**, Falls Church; Indiana University School of Medicine, 1956; age 59; died June 7, 1991. A plastic/reconstructive surgeon, he had been vice president and AMA delegate for the Medical Society of Virginia.

• **Charles M. Caravati, Sr., MD**, Richmond; Medical College of Virginia, 1922; age 91; died April 20, 1991. Chairman of the Gastroenterology Division at MCV 1958-63, he had received the Distinguished Service Award of the Southern Medical Association and was a Master and former Regent for Virginia of the American College of Physicians.

• **John Tilghman Hazel, MD**, Warrenton; Georgetown University School of Medicine, 1928; age 86; died March 8, 1991. A surgeon in Northern Virginia for 53 years, he was instrumental in the formation of Arlington Hospital and had been president of both the Arlington and Fauquier County Medical Societies.

• **Thornton S. Jennings, MD**, Charles Town, West Virginia; Medical College of Virginia, 1930; age 85; died November 13, 1990. A general practitioner, he retired in 1983 after 36 years with the Veterans Administration Medical Center in Martinsburg.

• **Stephen Rice Koller, MD**, Richmond internist; Mount Sinai School of Medicine, City University of New York, 1970; age 46; died March 22, 1991.

• **Sava M. Nedelcovych, MD**, Alexandria gynecologist; School of Medicine, University of Belgrad, Yugoslavia, 1952; age 66; died January 14, 1991, in an auto accident while on safari in San Mali, Africa. His wife, Anna N. Nedelcovych, MD, survives him.

• **John J. Nolan, MD**, thoracic/cardiovascular surgeon in Arlington; University of Pennsylvania School of Medicine, 1945; age 70; died May 3, 1991, of coronary artery disease. He had been president of the Arlington Medical Society and the Washington Metropolitan Society of Thoracic/Cardiovascular Surgeons.

• **Eugene Reyes Perez, MD**, former Virginia surgeon and medical administrator; McGill University Faculty of Medicine, Montreal; age 82; died August 9, 1990, in Orrtanna, Pennsylvania, where he was living in retire-

ment. Dr. Perez had been medical director of Petersburg General Hospital.

• **Simon Russi, MD**, Alexandria, retired pathologist; Regia University Medical School, Modena, Italy, 1935; age 80, died May 7, 1991. For 21 years director of pathology at Petersburg General Hospital, he had been president of the Southside Virginia Medical Society and the Virginia Society for Pathology.

• **George Henry Smith, Jr., MD**, Winchester; George Washington University School of Medicine, 1927; age 89; died November 15, 1990, of acute leukemia. He had been president of the Virginia Society of Ophthalmology and Otolaryngology.

• **Edward Somers White, MD**, Onancock; University of Virginia School of Medicine, 1955; age 61; died April 19, 1991. He had been associated in family practice on the Eastern Shore with his twin brother, the late Isaac S. White, MD.

## Memoir of Leslie Bond 1929-1991

*By Girard V. Thompson, Sr., MD*

Lester R. Bond, MD, died at his home in Gretna, Virginia, on February 21, 1991, at the age of 62 of cardiac complications and non-Hodgkins lymphoma. He was born in Roanoke, Virginia, and received his M.D. degree from the University of Virginia Medical School in 1954. He interned at Ohio State University and served two years in the U.S. Air Force with the Strategic Air Command.

Dr. Bond practiced in Gretna until his death. He was associated with Dr. W. G. Weimer at the Ramsey Memorial Medical Center. He was a member of the Danville-Pittsylvania Academy of Medicine and the Medical Society of Virginia. He was a state medical examiner for 30 years and was on the family practice staff of the Memorial Hospital of Danville.

Active in civic affairs, Dr. Bond was physician to the Gretna High School athletic teams and usually attended the games. He was an honorary member of the Gretna Rescue Squad, past member of the Gretna Jaycees, received the Junior Chamber of Commerce distinguished service award and was a member and past president of the Gretna Lions Club.

Survivors include his wife, Jacquelin Fisher Bond of Gretna, four sons, one daughter, three brothers and nine grandchildren.

Dr. Bond described his job as "people practice which was unpredictable, satisfying and fulfilling." He never regretted coming to the country to practice.

## Memoir of Leslie Rudolf 1927-1990

*By John B. Hanks, MD*

Leslie E. Rudolf, Jr., MD, FACS, died October 16, 1990, at his residence in Charlottesville, Virginia. At the time of his death Dr. Rudolf was the C. Bruce Morton professor and vice chairman of the Department of Surgery at the University of Virginia Health Sciences Center in Charlottesville.

Dr. Rudolf was born November 12, 1927, in New Rochelle, New York. He served in the U. S. Army Counter-Intelligence Corps after World War II in Europe. He graduated from Union College in 1951 and Cornell Medical College in 1955. He completed his surgical residency at Peter Brent Brigham Hospital in Boston, serving as chief resident surgeon in 1961.

Dr. Rudolf came to Charlottesville as an assistant professor of surgery in 1963. He rapidly rose through the ranks, becoming professor of surgery and vice chairman of the department in 1974. He was a Markle Scholar in Academic Medicine from 1966 to 1971. His research interests were in organ and tissue transplantation and preservation. He was instrumental in initiating the kidney transplant program at the University of Virginia Health Sciences Center.

His active service to the Charlottesville community was exemplified by his early involvement in the development of the Charlottesville/Albemarle Rescue Squad. Dr. Rudolf was a member of all the important surgical academic societies and was president of the Southeastern Surgical Congress in 1989. He received the Governor's citation for the Commonwealth of Virginia Emergency Medical Services in 1980.

His colleagues at the University of Virginia recognized his keen interests in medical student teaching, in resident evaluation and teaching and in the young surgical faculty. He contributed to many important internal committees at the University of Virginia and was instrumental in the development of many new programs, including pancreas, kidney and heart transplantation, as the Department of Surgery moved to the new hospital. Over and above Dr. Rudolf's distinguished academic accomplishments, he was a talented person with many diverse and scholarly pursuits and hobbies. His advice and counsel on topics ranging from Chinese cooking to orchid raising were sought by a wide spectrum of friends and admirers.

The Department of Surgery and the University of

Virginia Health Sciences Center have lost a valued friend, trusted advisor and loyal colleague. Our sympathies are extended to his wife, Melinda Robinson, and his four children, William, Barbara, Mary Christina and Leslie "Skip" Rudolf.

## Memoir of Porter Echols 1902-1990

*By William H. Barney, MD*

Porter Burks Echols, M.D. died in Lynchburg, Virginia, December 23, 1990. The husband of the late Hortense Reynolds Echols, he was also preceded in death by a son, Michael Carter Echols, and five brothers and a sister.

Born in Rockbridge County on February 5, 1902, he was a son of Nancy Carter and Ernest Echols. He matriculated at the University of Virginia at the age of 17 and received his MD degree in 1925. After an internship at the University of Virginia he trained at the New York Post Graduate Medical School in Eye, Ear, Nose and Throat.

Before opening his practice in Lynchburg in 1931 he worked for the State Health Department, providing medical care in the coal fields of Southwest Virginia, and his commitment to community service continued throughout his professional career. Upon establishing his practice in Lynchburg he worked at the Lynchburg Training School and for many years served in the ENT Clinic of the Lynchburg Health Department. During World War II, unable to enlist for physical reasons, he became a medical examiner for the Selective Service Boards in Richmond and Roanoke.

In 1962 he was joined in practice by his son, Dr. Porter B. Echols, Jr., and from then until his retirement he limited his practice to ophthalmology. In addition to his son he is survived by two brothers and three grandchildren.

He was a member of the Lynchburg Academy of Medicine, The Medical Society of Virginia, the American Medical Association and the Lynchburg Ophthalmological Society. He was a member of the 50-Year Clubs of both the MSV and the AMA and was a Thomas Jefferson Society Alumnus of the University of Virginia.

Dr. Echols was an avid hunter and fisherman. In 1946 he and four other physicians formed a group known as the "Doctors Trailer Club" which took spring and fall camping trips (in an old pop-up trailer) visiting various wild areas of the state. Dr. Echols was the last surviving member of the original group but the tradition has been carried on even today by the sons and grandsons of those who started it.

He was a lifelong member of the Episcopal Church, and the original Episcopal church at Glasgow in Rock-



bridge County was built on the Echols farm where he was born. He was buried in the Glasgow cemetery.

## Memoir of Tom Bithell 1930-1990

*By Charles E. Hess, MD*

Thomas C. Bithell was born in Salt Lake City, Utah, on August 19, 1930. He was the son of Afton Staines Bithell and the late Harold L. Bithell. He died on November 19, 1990.

Tom received his BS degree in biology in 1952 and his MD degree in 1955, both from the University of Utah. He was elected to Phi Kappa Phi, Phi Beta Kappa, and Alpha Omega Alpha. He completed his housestaff training in medicine at the Boston City Hospital, Harvard Service, in 1957, followed by a fellowship in hematology at the National Institutes of Health. He spent one year at Oxford University, England, and in 1961 returned to the University of Utah, initially as a fellow, then, in 1965, as a member of the faculty. He joined the faculty of the University of Virginia School of Medicine in 1969 and in 1976 was made professor of clinical pathology and internal medicine.

Tom was endowed with an exceptional intellect and was admired by all who knew him for his almost unlimited source of knowledge in many areas, from his subspecialty of hematology and coagulation to gardening, music, sports. His students, the housestaff, and his colleagues will remember him most as an absolutely superb teacher. He possessed that unique ability to digest an enormous amount of literature on a subject, to critically analyze it, and then to condense it into a state-of-the-art lecture, into which he interjected humor at opportune times to keep his audience interested. Not once, not twice, but four times he won the Robert B. Bean Award for excellence in basic science teaching.

His bibliography included 89 scientific publications, book chapters and abstracts. He was an editor and major contributor to *Wintrobe's Clinical Hematology* (the Bible of hematology), including the 9th edition to be published in 1992. He was a reviewer for many scientific journals and was invited to give many lectures.

He is survived by his mother; his wife, Vreni O. Bithell; two sons, Thomas and Gregory; two daughters, Amy Bithell and Lisa Kirk; and one granddaughter.

Tom will forever be missed by all who had the pleasure of being associated with him. I joined the University of Virginia faculty in 1969 when he did, and over the next 20 years I saw and talked to him almost every day. He taught me much.

## Memoir of A. D. Crosett 1927-1990

*By Robert J. Newman, MD,  
and Robert E. Hoyt, MD*

Dr. Alexander Davis Crosett, Jr., age 63, of Kilmarnock, died October 8, 1990, at his residence.

Dr. Crosett received a BS degree from Yale University in 1947 and an MD degree from the Yale University School of Medicine in 1950. He interned at the University of Minnesota Hospital and did his residency at Presbyterian Hospital in New York. He served as a radiologist with the U.S. Air Force Strategic Air Command with the rank of captain during the Korean War. From 1959 until 1978, Dr. Crosett served as attending radiologist and the Director of Radiology Services at Overlook Hospital in Summit, New Jersey, before moving to Kilmarnock, where he had been attending radiologist at Rappahannock General Hospital in Kilmarnock since 1978 and president of the medical staff from 1981 until 1983. He was also the founder and president of Chesapeake Mobile Imaging Services.

His memberships included the American Medical Association, the Medical Society of Virginia, Northern Neck Medical Association, Radiologic Society of North America, American Roentgen Ray Society, Society of Nuclear Medicine, Society of the Sigma Xi, American College of Radiology (fellow), and Peninsula Radiologic Society. He was president of the Northern Neck Medical Association from 1979 to 1980 and served as secretary for this organization until the time of his death. Dr. Crosett was an elder of Campbell Memorial Presbyterian Church in Weems and a member of their choir. He was active in community and church affairs in Summit and the Kilmarnock area.

Al Crosett was devoted to the practice of medicine in the Northern Neck and contributed much to the advancement of radiologic technology here. He will be remembered as a dedicated physician who was continually striving for improvements in quality of care. His life outside of medicine was rich and full as well. His wonderful family is an enduring tribute to his many human virtues. Al's death has brought great loss to our community, but the memories of his life will be cherished forever.

He is survived by his wife Adele Weaver Crosett; two children, Lynn Adele Crosett and Alexander Davis Crosett, III; his mother, Almena Downs Crosett; a daughter-in-law, Katherine Crosett; and one grandson, Alexander Davis Crosett, IV.



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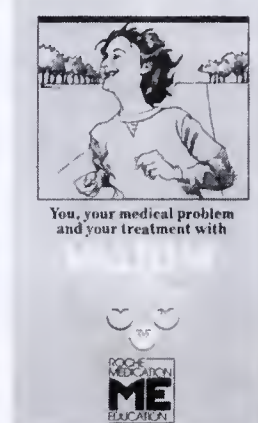
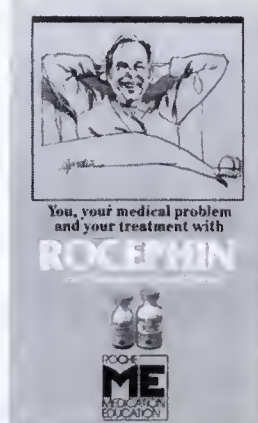
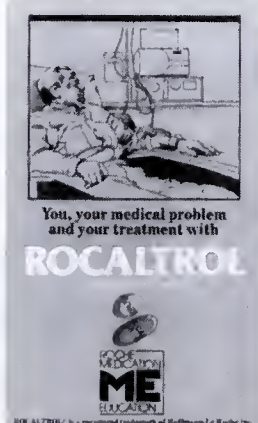
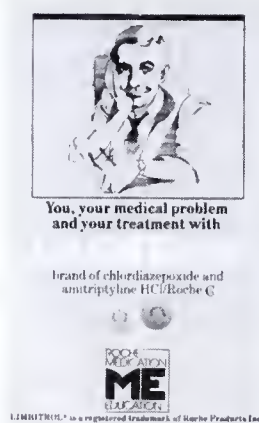
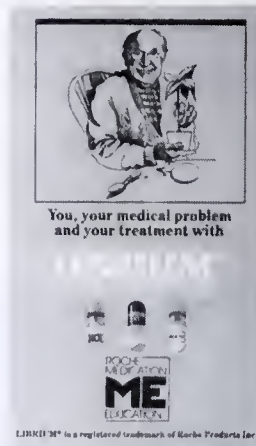
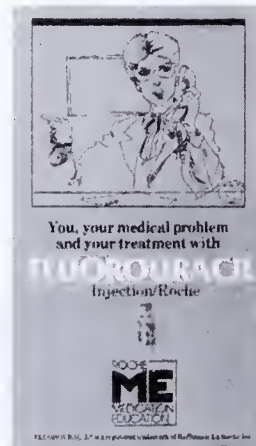
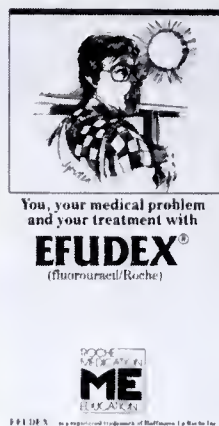
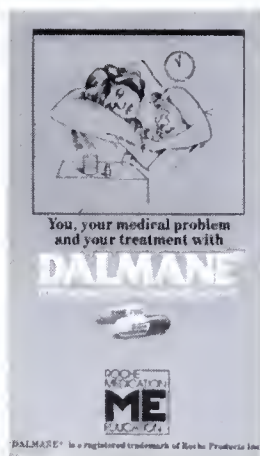
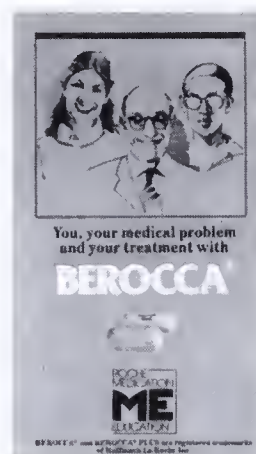
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**Joseph J. Lamb, MD**, Internal Medicine, 4660 Kenmore Avenue, Alexandria VA 22304

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**Susan G. Shook, MD**, Obstetrics/Gynecology, 5895 North 14th Street, Arlington VA 22205

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**Shawn S. Clausen, MD**, Family Practice, 11200-A Lee Highway, Fairfax VA 22030

**Lewis B. Eberly, MD**, Neurology, 3020 Hamaker Court, Fairfax VA 22031

**Guy M. Edmondson, MD**, Family Practice, 4001 Fair Ridge Drive, Fairfax VA 22033

**Robert B. Hashemiyoon, MD**, General Practice, 3917 Old Lee Highway, Fairfax VA 22030

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**Robert N. Kurtzke, MD**, Neurology, 3020 Hamaker Court, Fairfax VA 22031

**Bernadette N. Wells, MD**, Pediatrics, 9110 Fisteris Court, Springfield VA 22152

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**Christopher S. Walsh, MD**, Radiation Oncology, 1224 Dandridge Street, Fredericksburg VA 22401

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**William E. Gibbons, MD**, Reproductive Endocrinology, 825 Fairfax Avenue, Norfolk VA 23507

**Charles E. Horton, Jr., MD**, Urological surgery, 400 Gresham Drive, Norfolk VA 23507

**Jonathan P. Partington, MD**, Neurosurgery, 905 Redgate Avenue, Norfolk, VA 23507

**Larry O. Sharpe, MD**, Dermatology, 504 DePaul Atrium, Norfolk VA 23505

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*More new members next page*

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**Manmohan S. Khokhar, MD**, Physical Medicine/Rehabilitation, 1311 Palmyra Avenue, Richmond VA 23227

**George R. McBeath, MD**, Family Practice, 4906 Forest Hill Avenue, Richmond VA 23225

**George B. Newton, MD**, Vascular Surgery, 425 North Boulevard, Richmond VA 23220

**John C. Shallcross, Jr., MD**, Gastroenterology, 7605 Forest Avenue #211, Richmond VA 23229

**Mitchell L. Shiffman, MD**, Gastroenterology, Box 711, MCV Station, Richmond VA 23298

**John A. Spratt, MD**, Thoracic Surgery, Box 68, MCV Station, Richmond VA 23298

**Kenneth A. Steingold, MD**, Reproductive Endocrinology, 12010 Horncastle Place, Richmond VA 23233

**James A. Thompson, MD**, Cardiovascular Diseases, 7605 Forest Avenue, Richmond VA 23229

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**James H. Gardner, MD**, Internal Medicine, 1111-B South Jefferson Street, Roanoke VA 24016

**G. Gregory Ross, MD**, Internal Medicine, 1111-B South Jefferson Street, Roanoke VA 24016

**Andrew G. Roth, MD**, Plastic Surgery, 1030 South Jefferson Street, Roanoke VA 24016

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**Richard T. Kubota, MD**, Radiology, 220 University Boulevard, Harrisonburg VA 22801

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**William D. Ferrarraccio, MD**, Orthopedic Surgery, PO Box 2155, Pulaski VA 24301

**Pamela L. Gwathmey, MD**, Family Practice, 112 Oaklawn Avenue, Galax VA 24333

**William B. Gwathmey, MD**, Family Practice, 112 Oaklawn Avenue, Galax VA 24333

**Stephen B. Irvin, MD**, Family Practice, 199 Hospital Drive, Galax VA 24333

**Jayashree C. Veliyath, MD**, Internal Medicine, PO Box 579, Pulaski VA 24084

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**Linwood R. Spruiell, MD**, Anesthesiology, PO Box 1486, Suffolk VA 23434

**Andrew P. Zasada, MD**, Radiology, 4764 Schooner Boulevard, Suffolk VA 23435

### *Virginia Beach Medical Society*

**Paul W. Braunstein, Jr., MD**, Vascular Surgery, PO Box 4159, Virginia Beach VA 23454

**Thomas H. Scott, Jr., MD**, Pulmonary Diseases, 816 Independence Boulevard 2B, Virginia Beach VA 23455

**Mark J. Slepín, MD**, Emergency Medicine, 1060 First Colonial Road, Virginia Beach VA 23454

### *Williamsburg-James City County Medical Society*

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### *Residents*

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**Addison K. May, MD**, General Surgery, 231 Harvest Drive, Charlottesville VA 22901

**Lyle B. Montgomery, MD**, Psychiatry, Box 710, MCV Station, Richmond VA 23298

**Lauren M. Mozdy, MD**, Anesthesiology, 3008 Stony Lake Court, Richmond VA 23235

**Mark S. Jones, MD**, Psychiatry, 1711 Hancock Avenue, Norfolk VA 23509

**Michael J. Roy, MD**, Internal Medicine, 1400 South Edgewood Street, Arlington VA 22204

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#### CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

#### WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for anorectic effects.

#### PRECAUTIONS:

Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Patients on thyroid preparations and parents of children on thyroid therapy should be informed that replacement therapy is to be taken essentially for life. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pains, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.

Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

**Drug Interactions** — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started.

Cholestyramine binds both  $T_4$  and  $T_3$  in the intestine, thus impairing absorption of these thyroid hormones. Four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). Patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen-containing oral contraceptives are given.

**Drug/Laboratory Test Interactions** — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone, androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

**Carcinogenesis, Mutagenesis, And Impairment of Fertility** — A reported apparent association between prolonged thyroid therapy and breast cancer has not been confirmed. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

**Pregnancy-Category A** — The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women.

**Nursing Mothers** — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

**Pediatric Use** — The incidence of congenital hypothyroidism is relatively high. Routine determinations of serum ( $T_4$ ) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

#### ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

**OVERDOSAGE** — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism, which may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremors, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure. Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed.

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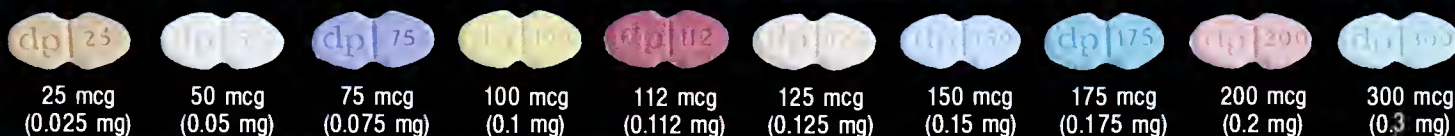
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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

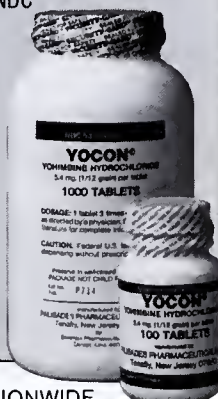
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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# WHO'S WHO

For his "outstanding accomplishments as a physician, teacher, community leader, and father," **Dr. James S. Harris**, Blackstone, was chosen Family Doctor of the Year by the Virginia Academy of Family Physicians. Gov. Douglas Wilder presented the award in a ceremony at the Governor's Mansion in Richmond. Dr. Harris is associate director of the Blackstone Family Practice Residency Program, serves on the Admissions Committee for the Medical College of Virginia, and is mayor of Blackstone.

A new distinguished professorship at the Medical College of Virginia honors **Dr. Edwin L. Kendig, Jr.**, Richmond, founder of the Child Chest Clinic at MCV and internationally known for his work in pediatric pulmonary disease. Under the chairmanship of **Dr. Barry V. Kirkpatrick**, colleague of Dr. Kendig at St. Mary's Hospital, the chair was underwritten in record time; the American Lung Association of Virginia turned its fourth annual research dinner dance into a fundraiser, and contributions from 220 of Dr. Kendig's peers, plus some MD groups, took the grand total to \$270,000.

A world-class collection of awards, medals, and appointments testify to Dr. Kendig's preeminence as a clinician. His capacity for leadership has taken him to the presidency of the American Academy of Pediatrics. Now in its fourth edition and selling steadily at home and abroad is the book he edited, *Disorders of the Respiratory Tract in Children*, and since 1982 this journal has been privileged to publish under his direction as Editor.

Five Medical Society of Virginia members figured in a recent release from the American College of Physi-

cians' Philadelphia headquarters.

**Dr. John M. Daniel III**, Richmond, has been elected to ACP fellowship, and the College has conferred its Laureate Award on **Dr. William D. Lewis**, Martinsville; **Dr. Charles H. Sackett**, Lynchburg; **Dr. Emmett C. Mathews**, Richmond; and **Dr. Robert A. Abernathy**, Richlands, for their many years of "good medical citizenship."

The Jaycees of Great Bridge tapped **Dr. Juan Montero II**, thoracic surgeon in Chesapeake, for their 1991 First Citizen Award, citing the scope and vigor of his community involvement. Dr. Montero was the recipient of the 1979 Chesapeake Community Service Award for his services to migrant farm workers on the Eastern Shore, has managed/coached Little League baseball, and is a team leader for the United Way Campaign.

Also in Chesapeake, **Dr. Pat L. Aulicino** was elected president of the Chesapeake Medical Society, and **Dr. Prudencio Mendez, Jr.**, was re-elected secretary.

Chatham Hall's fifth annual faculty seminar series honored **Dr. Hugh H. Willis, Jr.**, who has conducted a general practice in the Town of Chatham for over 40 years and who has close ties to the girls' school through his daughters, Sallie and Nell, both Chatham Hall graduates.

A reception at the Chesapeake National Bank, Kilmarnock, honored **Dr. A. L. Van Name** of Urbanna for his contributions to the citizens of Middlesex County as doctor, as civic leader, and as artist. On display to illustrate the last role were limited edition prints of Dr. Van Name's pen and ink sketches of Chesapeake Bay schooners, which are his artistic specialty. (For an example, turn to

page 181 of this issue.)

Dr. Van Name retired in 1986 after 43 years of general practice in Urbanna and the surrounding area. His civic contributions include the organization of what is now the Central Middlesex Volunteer Rescue Squad; formation of a preschool clinic for county children; Boy Scout leadership; and 12 years of service on the town council.

**Dr. Michael D. Dickens**, Charlottesville, is the new president of the Virginia Pediatric Society and the Virginia Chapter, American Academy of Pediatrics.

**Dr. Parker C. Dooley**, Onley, has agreed to serve another term as president of the Accomack County Medical Society, and the members have prevailed upon **Dr. Belle D. Fears**, Accomack, to return to the the post of secretary.

Gov. Douglas Wilder has appointed **Dr. David M. Smith**, family physician in Forest, to serve on the Industrial Advisory Board of the Central Virginia Governor's School for advanced students in mathematics and science located in Lynchburg.

Bridgewater College has honored **Dr. Alvin E. Conner**, retired Manassas pediatrician; **Dr. J. Paul Wampler**, Manassas surgeon; and Dr. Wampler's wife, Priscilla Wakeman Wampler, with outstanding service awards for their contributions to the community. The awards were conferred during the college's annual Founder's Day dinner. All three honorees are Bridgewater graduates.

At the annual meeting of the Virginia Surgical Society, **Dr. Robert E. Berry**, Roanoke, was elected president, and **Dr. William E. Gayle, Jr.**, Lynchburg, was reelected secretary.

At Longwood College's homecoming ceremony, **Dr. Margaret Lee (Molly) Hagan**, Fincastle, was given the college's Alumni Achievement Award. She is medical director of the Alleghany Health District.



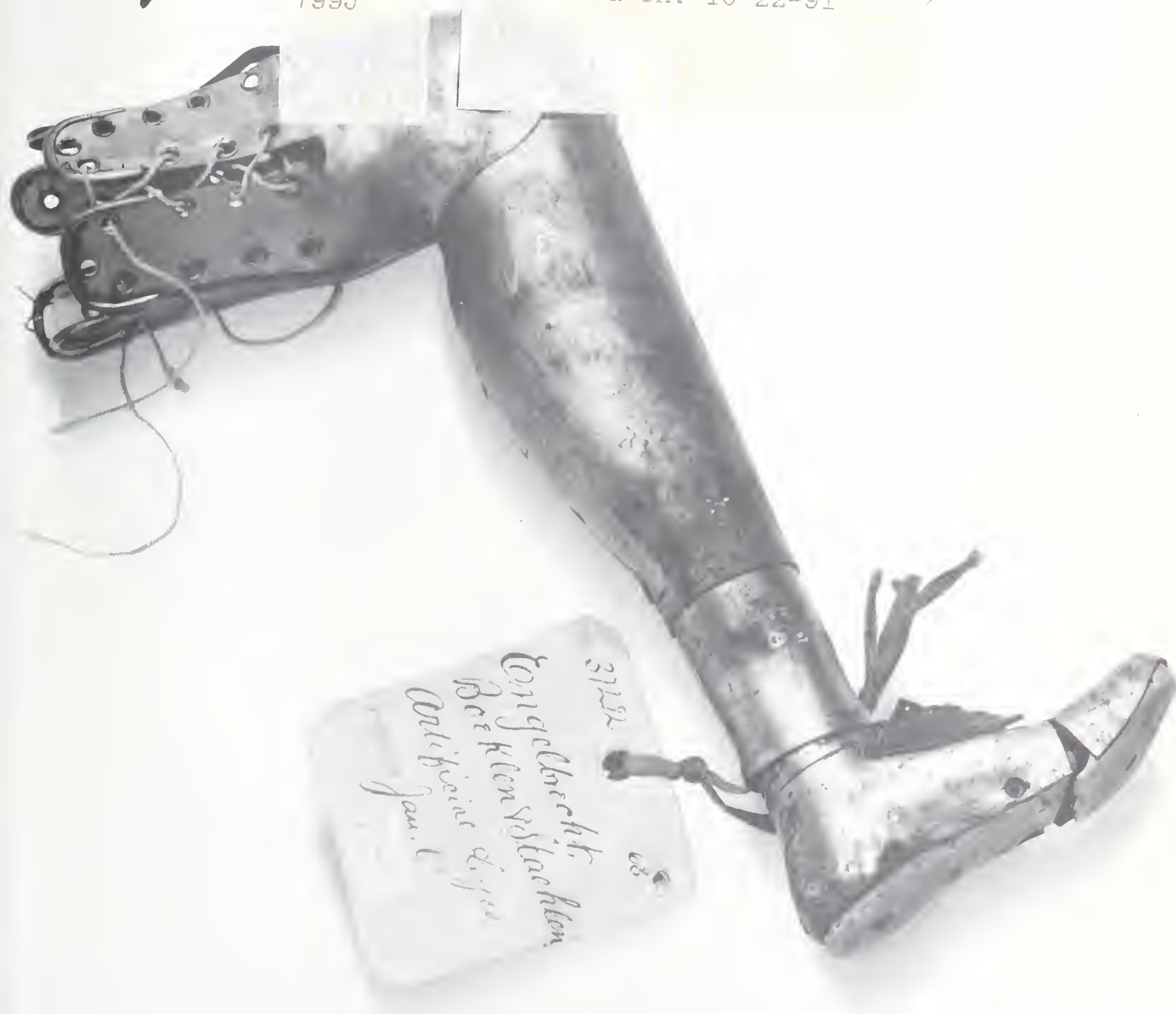
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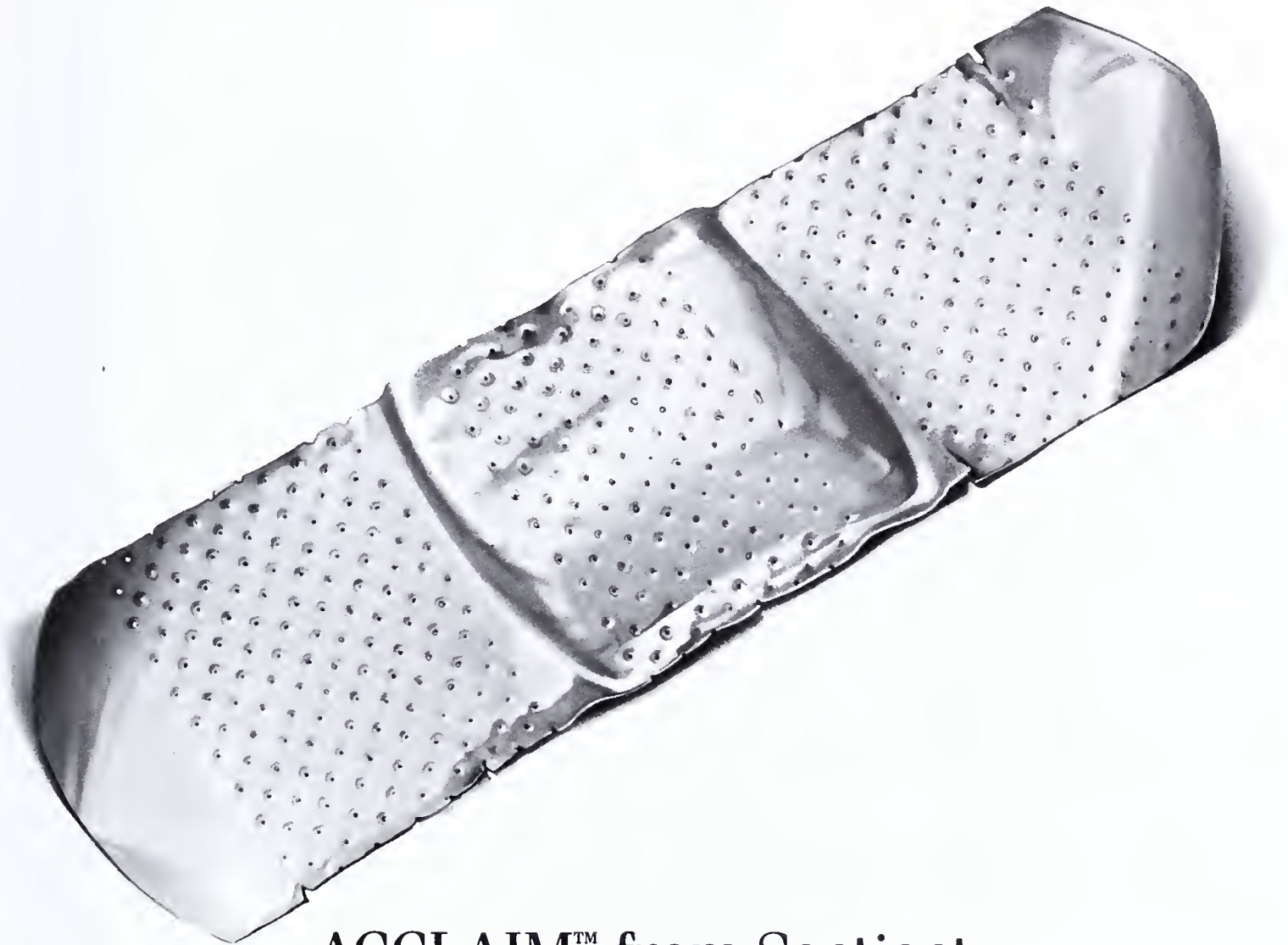
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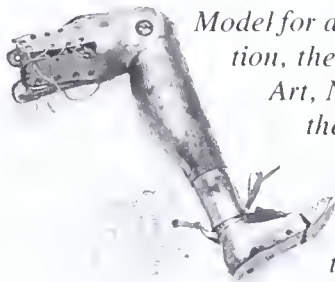
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Volume 118/Number 4

Fall 1991 (Oct/Nov/Dec)

ON THE COVER

- 222 **Confederate Medicine: the View from Virginia** "A good surgeon could amputate a leg in a couple of minutes."  
JAMES O. BREEDEN



*Model for a prosthesis, 1863, from the Cliff Petersen Collection, the Cooper Union for Advancement of Science and Art, New York. Photograph by Joanne Savio courtesy the Cooper Union. The quote is from "Patents and Medicine," an article by Stanley B. Burns, MD, for the catalog of a Cooper Union exhibit (1991) titled "A Better Mousetrap: Patents and the Process of Invention".*

UP FRONT

- 206 **In Appreciation** Virginia's congressional delegation sends a letter to HCFA's administrator deploring the proposed reductions in Medicare payments to physicians  
JOHN A. OWEN, JR.  
208 **More Letters** L. GREGG HALLORAN and PAUL S. RÖCHMIS  
213 **Special Report: Final Safe Harbor Regs Bear Down on MD-Investment Referrals** Available on request, a legal interpretation of the regulations by Sandra L. Kramer and Patrick C. Devine, Jr.

MEDICINE

- 233 **Pneumoperitoneum and Portal Venous Air After Barium Enema**  
MORTON L. MOSS and JOHN T. MAZZEO  
235 **Celiac Artery Aneurysms: Case Reports**  
W. STEPHEN PHILLIPS, QUENTIN MACMANUS, and  
EDWARD A. LEFRAK  
239 **Abstracts of the Virginia Thoracic Society Research Symposium**  
242 **Abstracts of the Virginia Dermatological Society's Annual Meeting**

RECOLLECTIONS

- 236 **Too Much Heart** CURTIS G. TRIBBLE

FROM THE ROSTRUM

- 247 **An Ordinary Life** JOHN A. OWEN, JR.

*continued over*

# INDEX TO ADVERTISERS

Clements & Company .....	259
Coastal Emergency Services of Richmond.....	267
Cumberland Hospital .....	204-5
The Doctors Company.....	203
Doctors Insurance Reciprocal	221
Health of Virginia .....	256
Insurance Corporation of America.....	217
The Kirwan Companies.....	267
Lewis-Gale Clinic, Inc. ....	257
Eli Lilly & Company .....	262-3
Lynchburg Emergency Physicians, Inc.....	265
Medical Protective Company .....	232, 264
National Diagnostic Oncology	208
Nutronics .....	210
Palisades Pharmaceuticals....	260
John P. Pearl & Associates...	214
Peoples Drug Stores.....	261
Reed & Carnrick.....	212
Richmond Headache Center .....	209
Riverside Laboratories.....	255
Roche Products .....	218
Saint Albans Psychiatric Hospital.....	253
G. D. Searle & Co. ....	Cov 4
Sentient Systems.....	199
The Saint Paul.....	249
State Volunteer Mutual Insurance Company .....	200
The Sterling Group.....	266
Sun Room Company .....	208
U.S. Air Force .....	258
U.S. Navy .....	255
WMI Medical Services .....	254

## BOOKS

215	<i>Call Me a Doctor: Tales of Six Medical Men Who Went Elsewhere and Did Other Things</i> , by Jack Griffiths Reviewed by JOHN L. GUERRANT
216	<i>Prescriptions for All Occasions</i> , by the Medical Society of Virginia Auxiliary

## EDITORIALS

245	<b>A Hard Day's Work</b> H. S. CAMPELL
245	<b>The Doctors' Plan Pickup Trucks</b>
246	<b>Routine HIV Serology</b> E. L. KENDIG, JR.

## OBITUARY

250	<b>Notices of Deaths of MSV Members</b> <b>Memoir of Clyde O'Brien</b> JOHN A. MATHEWS <b>Memoir of C. W. Coppedge</b> RAY A. MOORE, JR.
251	<b>Memoir of Russell Bowers</b> CUSTIS L. COLEMAN, E. RANDOLPH TRICE, and EDWIN S. WYSOR <b>Memoir of Jack W. Hall</b> CLIFFORD G. GADDY and LAWRENCE G. FEHRENBAKER
252	<b>Memoir of Jack Ulmer</b> WILLIAM M. EAGLES <b>Memoir of Jim Beaton</b> WILLIAM L. SAGER

## DEPARTMENTS

219	<b>Who's Who</b>
246	<b>Medical Society of Virginia Officers</b>
254	<b>New MSV Members</b>
259	<b>Meetings about Medicine</b>
265	<b>Classified Advertisements</b>







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And, because recreation is an important part of head injury therapy, Cumberland makes sure its patients spend time in creative play, exercise and recreational therapy—on the playground and in the gym. At Cumberland kids are still kids.



## Cumberland Has Successful Experience Treating Head-Injuries

Cumberland is a JCAHO-accredited hospital, with eight years' experience treating patients with all levels of head injuries. This table shows the percentage of patients admitted to Cumberland at each RLA level during the past three years:

RLA Level 1	2.0%
RLA Level 2	45.0%
RLA Level 3	16.8%
RLA Level 4	15.7%
RLA Level 5	5.3%
RLA Level 6	5.2%
RLA Level 7	6.3%
RLA Level 8	3.2%

In addition, Cumberland has the experience treating young patients with many types of head injuries. This table shows the percentage of patients admitted with head injuries resulting from the following causes:

Automobile accident	44.0%
Pedestrian accident	15.2%
Bicycle accident	8.2%
ATV accident	5.3%
Skateboard	2.1%
All others	30.4%

## Cumberland's Staff

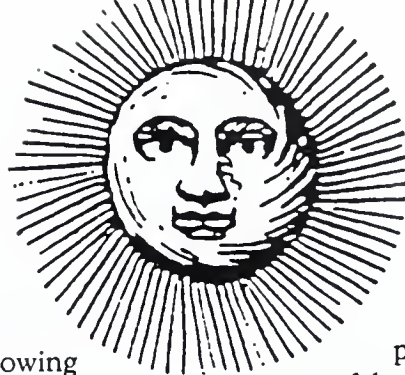
Because Cumberland is a hospital, and not just a rehab center, you can be confident that treatment is delivered by licensed rehabilitation professionals and other accredited hospital staff, all under the direction of an admitting physician. All physicians on Cumberland's admitting staff are board-certified in their specialty, and dedicated to the treatment of head-injured patients. The staff includes Donald A. Taylor, M.D., *Pediatric Neurologist*, Michael J. Decker, M.D., *Physiatrist*, Daniel N. Davidow, M.D., *Pediatrician*, and James E. Sellman, M.D., *Pediatric Psychiatrist*.

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Here, patients and their families can escape the hectic pace of everyday life and refocus their lives on the rehabilitation process.

At dawn and dusk, deer can often be seen grazing at the edge of the woods around the hospital, and flocks of Canada geese stop by to feed and rest on their journeys North and South.



## Cumberland Patients Recover

Cumberland has a proven record of successful treatment and recovery with head-injured patients. In a recent study conducted jointly with the Medical College of Virginia Hospitals, of 36 patients at RLA 4 or below who were admitted to Cumberland within 180 days post-injury, 22 made substantial improvement of two or more levels on the RLA scale, while 9 of the remaining 14 patients improved by one RLA level. In the same study, it was noted that 10 of 16 patients admitted 180 days post-injury in a vegetative state improved by two or more levels on the RLA scale.

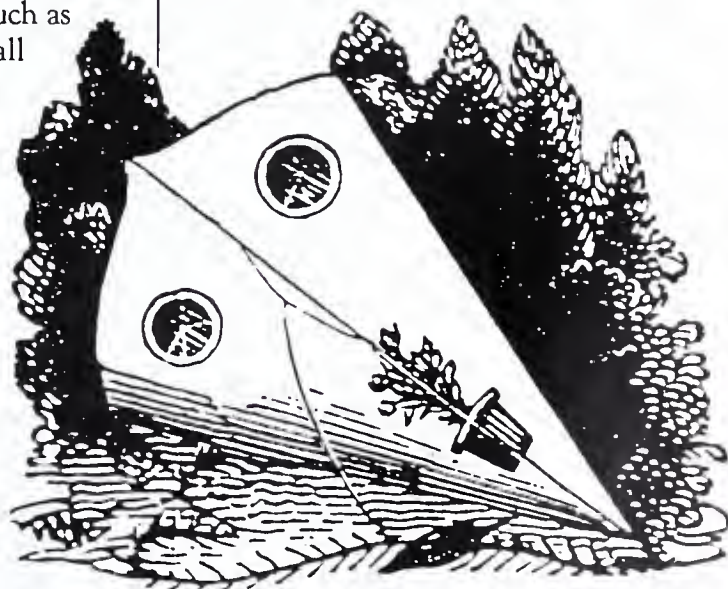
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# IN APPRECIATION

The physicians of Virginia should be proud of their representatives in Congress, justly confident of the respect and esteem in which the Medical Society of Virginia is held by them, and deeply appreciative of their efforts.

Do you remember how urgently you wrote to your representatives and senators last July and August? How hard you worked to explain the problems we foresaw in the HCFA's proposed Medicare reimbursement rules? Now read the composite letter sent by them to Gail Wilensky and see if they got the message. Can there be any doubt now that we work together, stand together, and speak together on issues like this? *Res ipsa loquitur*.

We have said "Please." Now it's time to say "Thank You." --J.A.O.

Congress of the United States  
Washington, DC 20515

July 31, 1991

Gail R. Wilensky, Ph.D.  
Administrator  
Health Care Financing Administration  
Department of Health and Human Services  
6325 Security Boulevard  
Baltimore, MD 21207

Dear Dr. Wilensky:

We are writing to express our concern about the proposed payment levels in the June 5, 1991 Notice of Proposed Rule Making (NPRM) on Medicare physician payment reform. Although the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) specified budget neutrality in converting to a Resource-Based Relative Value Scale (RBRVS), the proposed rule reflects a devastating immediate 16% reduction in the schedule's initial conversion factor. Overall payments, not just payments per service, will be reduced by this 16% payment reduction. We believe this will adversely affect Virginia's, as well as the nation's, physicians and senior citizens.

We believe that the proposed 16% reduction in the conversion factor results from a misinterpretation by your agency of the mandate for budget neutrality contained in OBRA '89, as well as from inappropriate and improper assumptions about anticipated physician behavior in response to payment reform. OBRA '89 requires the agency to establish a conversion factor such that aggregate Medicare expenditures for physician services will be the same as they would have been under a continuous the current payment system. You have interpreted this provision as requiring two reductions in the conversion factor: one to offset volume increases that you predict will occur as a behavioral response to payment reductions; and one to offset spending projected to result from the payment system's formula for 1992.

The rule includes a provision for a 50% "behavioral" increase based upon the assumption that doctors will increase of services billed to Medicare to offset the reduced reimbursement rates. This was included even though research failed to prove such activities would take addition, Physician Payment Review Commission (PPRC) representatives testified that the behavioral offset was two to three times higher than necessary.



Gail R. Wilensky, Ph.D.  
Page 2

were justified.

Furthermore, because you estimate the transition formula will lead to an increase in Medicare spending in 1992 as a result of payment increases occurring faster than payment decreases, you propose a payment reduction to ameliorate this. We believe OBRA '89 requires that the budget neutral conversion factor is to be calculated "without regard" to the transition paragraphs and their potential budget consequences. This is consistent with Congress' intent.

Lastly, since senior citizens' health care problems are more acute and often require the skills and services of highly trained specialists, the deep immediate cuts incurred by many specialists may result in those specialists refusing to treat Medicare patients, thus jeopardizing America's health care delivery system.

With this in mind, we urge you to revise the proposed rule so that it is budget neutral in nature, and allows for a fair implementation of the Resource-Based Relative Value Scale.

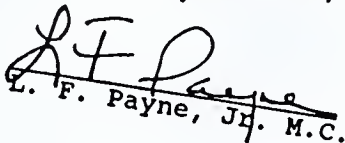
With kind regards, we are

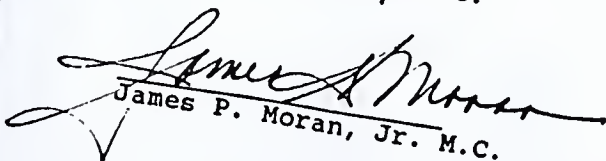
Sincerely,

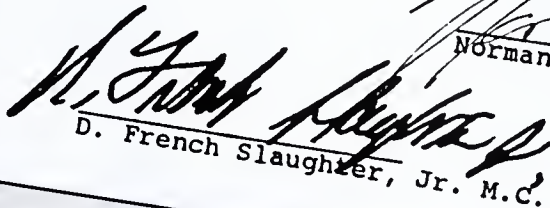
  
John Warner, U.S.S.

  
Tom Bliley, M.C.

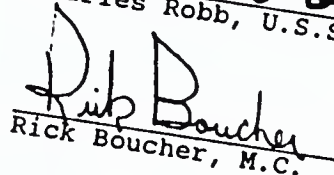
  
Herbert H. Bateman, M.C.

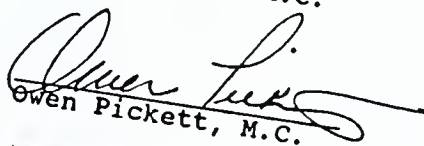
  
L. F. Payne, Jr. M.C.

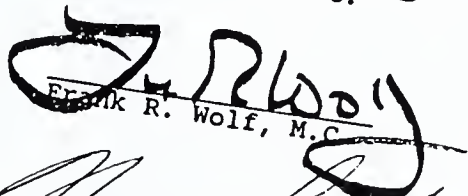
  
James P. Moran, Jr. M.C.

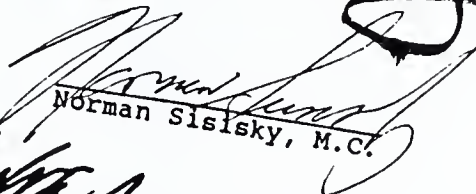
  
D. French Slaughter, Jr. M.C.

  
Charles Robb, U.S.S.

  
Rick Boucher, M.C.

  
Owen Pickett, M.C.

  
Frank R. Wolf, M.C.

  
Norman Sisisky, M.C.

Note: Congressman James R. Olin's signature does not appear above because he preferred to send his own letter.

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**LETTERS**

**We welcome your Letters to the Editor.**

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**Deplores cost/benefit ratio  
of precertification program**

I am motivated to write after reading the most recent Annual Data Report from the Medical Society of Virginia Review Organization (MSVRO) regarding the Medicare precertification program for selected surgical procedures.<sup>1</sup>

The data show that only 13 of 44,867 (0.03%) cases were denied and suggest that most, if not all, of the denials were among retrospectively reviewed cases (Table 1). Moreover, almost all of the denials were for cataract surgery (11 of 13) and appear to have been for a physician assistant during the procedure.

**Table 1. Medicare Precertification Review 4/1/90-3/31/91.<sup>1</sup>**

Procedure	Authorized	Denied*
Carotid endarterectomy	1,004	0
Cataract surgery, including second surgical assistant	22,778	11
Cholecystectomy	2,896	2
Coronary bypass with graft	2,897	0
Hysterectomy	1,247	0
Inguinal hernia repair	2,906	0
Laminectomy	673	0
Major joint replacement, knee or hip	4,235	0
Percutaneous angioplasty	1,888	0
Prostatectomy	4,330	0
TOTAL	44,854	13

*\* Includes retrospectively reviewed cases*

The cost of this program seems to me extraordinary for the meager benefit derived. Assuming only 10 minutes is expended on each of these transactions times the three people involved (the MSVRO person, myself as surgeon, and the hospital person), not to mention the time involved in records keeping and computer entry, I calculate close to 22,500 hours were expended to deny payments primarily for a physician surgical assistant at 11 of 22,778 cataract surgeries.

It appears, therefore, that we have spent over \$390,000 in administrative costs (assuming a people cost of \$17.50 per hour) to save a meager sum in surgical fees for eye surgery. Is it any wonder, then, that we have the most expensive health care system in

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the civilized world? And everyone is mad about it!

I am certain this program represents but one of a myriad of similar ones that squander our health care resources, and I hope Virginia physicians can and will take a leadership position in reforming the extravagantly wasteful systems in which we are forced to work and for which we receive so much criticism.

L. Gregg Halloran, MD

5855 Bremo Road, Suite 402  
Richmond VA 23226

1. MSVRO Reports (newsletter), Vol. 7, No. 3, May 1991

**The MSVRO's president, Dr. Philip T. Rodilosso, replies as follows:**

Quite appropriately, Dr. Halloran noted that the preadmission certification system for Medicare has been a great waste of money. The leadership of the MSVRO strongly opposed the initiation of the present precertification system when federal officials advocated its establishment some years ago. We contended then that it would be a paper shuffle with little positive effect. It turns out we were correct. Consequently, I am pleased to report that the Medicare Program will halt the present preadmission requirement on or about October 1, 1991. Apparently, CHAMPUS will continue this activity for the foreseeable future, but the ability of the "feds" at the Health Care Financing Administration (HCFA) to learn from the data is

encouraging. CHAMPUS may follow suit.

Over time, the dialogue between the physician community and HCFA has improved. As the partnership matures, our advice may be afforded serious consideration earlier in the decision process. This could help avoid in the future costly mistakes like preadmission review.

**Seeing a Shanghai doctor about an arthritic knee**

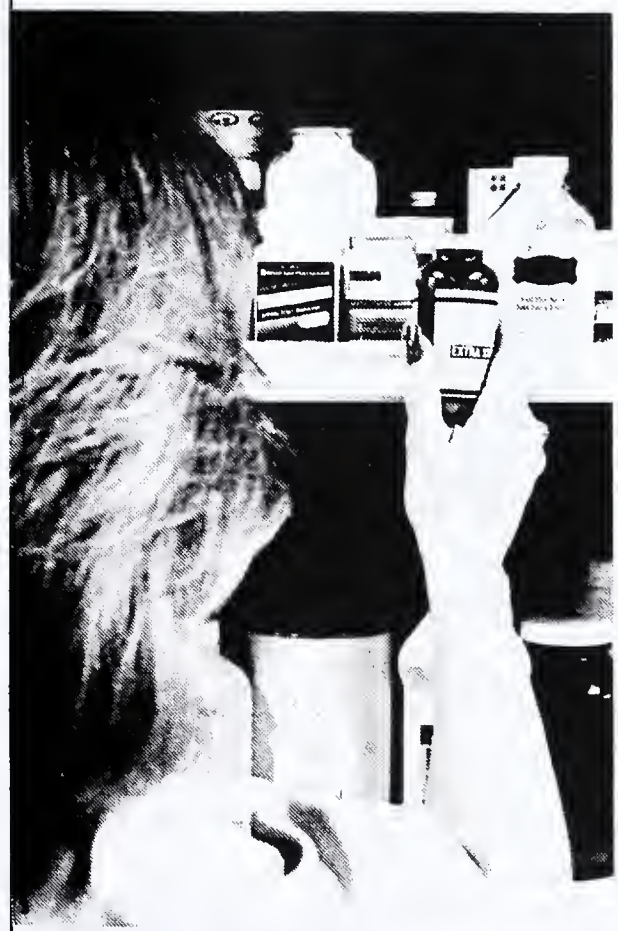
I have received an interesting letter from a patient who is working for the United States in Shanghai and have selected passages describing her recent medical experiences there.

Paul S. Rochmis, MD

3027 Javier Road  
Fairfax, VA 22031

*About six weeks ago I started having some pain in my right knee. It steadily got worse. I used up all the Clinoril I had. In January it had gotten so bad that I couldn't walk up stairs at all. I decided I would try acupuncture.*

*I made an appointment with the director of the acupuncture clinic at a local hospital, Dr. Tang, and when I went to see him I was shown into a very small room with a table, two chairs, and a wooden cot. He*



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## Buttery Named to City Post

In a move that will take him but a few blocks across downtown Richmond, Dr. C.M.G. Buttery, who earlier this year announced he would be leaving his post as Virginia's Commissioner of Health, has been named director of Richmond's Department of Health, a post that has been vacant for two years. Dr. Buttery is to take up his new duties on the 12th of this month. He had headed the state department since 1986.

*asked many questions and felt my knee and said I must have an x-ray and a blood test. After finding out that they use disposable needles, I agreed to the blood test. The nurse did a fine job, although I thought I would freeze before she finished because the temperature in the room wasn't over 55 degrees, if that. Then we went down the hall, which was not heated at all, to the x-ray room, where there was a space heater in one corner. The x-ray machine must have been one of the first ever made but it did the job and we went back to the doctor.*

*He started massaging the sore knee area very vigorously, and whenever he could tell that a particular place hurt, he massaged all the harder. Then he came over with a pan full of needles, and I found out*

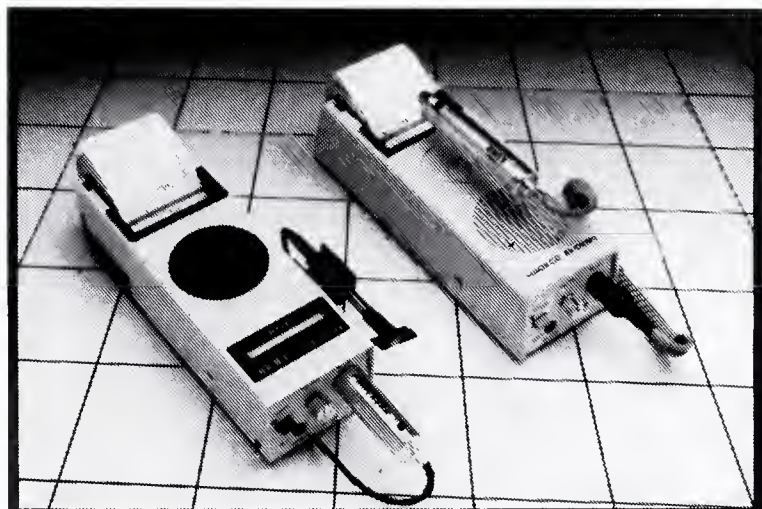
*that they do use disposable needles but they don't dispose of them after usage. I told him he could never use a needle on me that didn't come fresh from the vacuum-sealed package. He started squeezing and pressing the knee, and when he found a place that really hurt he took the needle and jabbed it in there. That didn't hurt, but when he moved the needle around until he apparently found the inflammation, it felt like an electric shock. As soon as that happened, he pulled the needle out. He did this five times all around the kneecap. Then he massaged again, and that hurt more than the needles, but the nurse came in with some kind of concoction spread on a piece of thin material about 4×4 inches and put it on my knee, and it felt much better. This was a Chinese herbal medicine, I was told, and it was very soothing. Then they put some sort of lamp over the knee and went away for 20 minutes. When he came back he gave me two kinds of herbal medicine and charged me about \$50; that included the three x-rays, blood test, medicine, treatment—the works.*

*I have now had four treatments and sometimes I think things are better and sometimes I am sure they are not. He has taken me off the herbal medication and put me on something called naproxen. If you think this is something that is not good for me to take, please let me know.*

*Name withheld on request*

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# WHO WILL BE SITTING IN THESE SEATS IN 1992?

Virginia physicians should be alarmed by the way political decisions affect the practice of medicine. You have a choice in the November 5th election as to who will make those decisions. This year all 140 seats in the Virginia General Assembly are open to elections, and any legislators friendly to physician's issues are being challenged.

The pressure to raise the cap on medical malpractice awards is mounting. The trial lawyers have made it clear that this issue is a primary target. Physicians need to know that their legislators will vote to uphold this ceiling.

Allied practitioners are pushing to extend their scope of practice into the practice of medicine. Physical therapists want direct access to patients. Optometrists are pushing the parameters on therapeutic drug use. Nurse midwives are



seeking independence from the supervision of physicians.

These groups are organized. You've got to be organized too. That takes VaMPAC dollars. VaMPAC works. The legislators listen.

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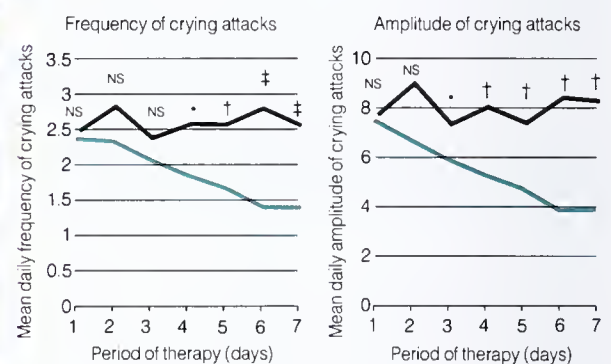
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1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508.

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PZ24



## *Fraud and Abuse Laws*

# Final Safe Harbor Regs Bear Down on MD-Investment Referrals

Final regulations creating eleven "safe harbors" from the Medicare and Medicaid fraud and abuse laws issued from the Office of Inspector General (OIG) on July 29, 1991. They differ in several important respects from both the proposed regulations released in 1989<sup>1</sup> and the so-called "draft" final regulations circulated later that year; thus arrangements structured earlier may not comply with these new, final regulations.

For example, the final regs tighten the investment standards for physician-owned limited partnerships and joint ventures. No more than 40% of investors can be in a position to make or influence referrals (60% was the figure in earlier versions), and no more than 40% of revenues can come from investor referrals.

Sandra L. Kramer, the Medical Society of Virginia's general counsel, and Norfolk attorney Patrick C. Devine, Jr., have written a concise legal interpretation of the new regulations as they may affect the practices of MSV members. To receive a free copy, fill out and mail the coupon below.

The authors warn at the outset that the Medicare and Medicaid fraud and abuse laws are so broad that harmless or even beneficial commercial arrangements are possible violations of the statute; yet a violation is a felony (punishable by fines of up to \$25,000 and up to five years of imprisonment) and a basis for exclusion from participation in Medicare and Medicaid. Only the business activities identified by the OIG as safe harbors are immune from criminal prosecution or program exclusion.

The two attorneys also emphasize that existing activities became sub-

ject to these regulations as of their date of issuance, July 29, and no transition time is provided.

Moreover, they point out, the OIG declined to publish advisory opinions and refuses to permit substantial or good faith compliance to satisfy a safe harbor, although it has indicated that it will use its discretion "to be fair" to providers who are "working with diligence and good faith to restructure" established arrangements to bring them into compliance.

In most instances, say the attorneys, all of a safe harbor's provisions must be met to ensure protection. And if you are involved in two or more activities that could qualify for safe harbors, the OIG expects you to comply with each applicable safe harbor.

Kramer and Devine examine in greatest detail the safe harbor on investment interests, especially the different rules for investments in "small" (e.g., limited partnerships and other joint ventures) and "large" businesses.

The attorneys give importance also to the safe harbors on space/

equipment rental and personal services/management contracts, for which there are similar requirements, and on sales of practices.

Are additional safe harbors likely to be issued? Yes, say the two attorneys, the OIG has already signalled its intent to consider the development of safe harbors for HMOs, PPOs, and other managed care plans; entities composed exclusively of active investors; purchases of group practices; arrangements that subsidize a practitioner's malpractice premiums; and traditional cross referral arrangements where no money is exchanged, e.g., primary care practitioner and specialist or within a group practice.

Kramer and Devine note that the safe harbor regulations do not apply to the Stark bill (Ethics in Patient Referrals Act), which becomes effective on January 1, 1992. If conduct is protected under the safe harbor regulations but violates the Stark bill, the Stark bill will still apply.

The article was designed to alert Virginia physicians to the basic implications of these new regulations. It is not intended as a substitute for consultation with your legal counsel or accountant.

—A.G.

1. Grad JD, Logan MP. What you should know about the proposed "safe" harbors. *Va Med* 1989;116: 211-214.

**PLEASE SEND ME a copy of  
"Fraud and Abuse Safe Harbor Regulations Issued,"  
by Sandra L. Kramer and Patrick C. Devine, Jr.**

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# BOOKS

**Call Me a Doctor: Tales of Six Medical Men Who Went Elsewhere and Did Other Things**, by Jack Griffiths, MD. The American Spectator, Arlington, Virginia, 1990, 244 pp, paperback, \$15.95.

Dr. Jack Griffiths, who was a classmate of mine at the University of Virginia in the 1930s, has written a delightful book about an odd group of physicians. They were chosen because they were adventurers who wandered from the routine practice of medicine. The two early physicians were

active in the first part of the 19th century. James Long (1793-1822) served as a physician with Gen. Andrew Jackson at New Orleans and later became involved in the Mexican and Texas wars. The other, James Wilkinson (1757-1825), studied medicine in Philadelphia with Dr. Benjamin Rush, served as an officer in the Continental Army, and was closely associated with many famous Americans, including George Washington.

William Walker (1824-1860) had a thorough medical education—a degree from University of Pennsylvania plus two additional years of study in Europe—but he was too restless to practice medicine. For a while he was a lawyer and a newspaper publisher and later became involved in revolutions in Nicaragua, where he became a general but was no more successful than current Americans. A firing squad ended his life.

Leander Jameson (1853-1917) was an honor student at the University of London, where he received his medical degree and became a surgeon. Responding to an appeal posted on the hospital notice board, he went to South Africa, where he developed a successful practice but abandoned it to become a close associate of Cecil Rhodes. He became Prime Minister of the Cape Colony, and later was chairman of the Charter Company (Cecil Rhodes Holding Company). He received many honors, including a baronetcy conferred by King George V.

Frederick Cook (1865-1940) practiced medicine in Brooklyn but gave

that up to go with Robert E. Peary on an Arctic expedition, thus beginning a career as an explorer. Peary praised him highly for his medical skills, but later they had a bitter quarrel about who was the first to reach the North Pole. In numerous other expeditions, he survived terrible cold and other hardships and was able to save the lives of companions by treating their injuries and teaching them how to survive when trapped for many months in the ice. His books and lecture tours about his explorations were very successful. In his later years, he became involved in Texas oil companies, but because he exaggerated the prospects of his companies, he was convicted of using the mails to defraud and spent time in prison.

Leonard Wood (1860-1927) is by far the most famous of this interesting group of doctors. Soon after receiving his medical degree from Harvard, he served as an army doctor in the Indian Wars in Arizona, riding with the troops as they chased the Indians and receiving the Congressional Medal of Honor. In 1896, he began serving in Washington with the U.S. Army Chief of Staff and became closely associated with many important people, including Presidents Cleveland and McKinley. During the Spanish American War, he helped recruit and train the famous Rough Riders and became their commanding officer. Theodore Roosevelt was second in command and they became best friends. Next he was a successful military governor in Cuba and later Army Chief of

Staff, where his leadership helped prepare the Army for World War I. Many thought he would be nominated for president by the Republicans, but Warren Harding beat him out. He died in 1927 during an operation for a brain tumor by Dr. Harvey Cushing.

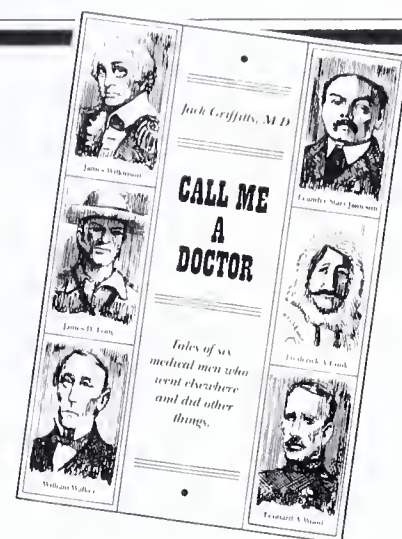
Dr. Griffiths' descriptions of these remarkable physicians who strayed from their medical careers exhibit extensive research. There is a bibliography at the end of each biography. The stories are filled with information and include skillfully inserted letters from friends and family members that make the people come alive. I commend this short volume to anyone who would like to meet some strange characters.

Jack Griffiths has continued a friend of mine since our days at UVA. He was an excellent student and I have always been grateful to him for the help he gave me. Since leaving school, he has had a distinguished career as director of a large blood bank in Miami, Florida, where he made valuable contributions to immunology and the science of blood banking, and was also a manufacturer of reagents used in blood banking. Since retiring he has been writing a column for his local newspaper, the *Riverland News*, and has finished a novel.

JOHN L. GUERRANT, MD

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Charlottesville VA 22908

*The book may be ordered from the American Spectator, PO Box 549,*





Arlington VA 22216, for \$15.95 plus \$2 for postage/handling.

**Prescriptions for All Occasions**, by the Medical Society of Virginia Auxiliary. Hartwell, Georgia, Calico Kitchen Press, 1990, spiral-bound hardcover, drawings by Evelyn Carr, indexed, 296 pp, \$15.

This is the book whose initial printing generated a \$34,000 grant for breast cancer research in Virginia, and a second printing will be available November 1st. It is a cookbook of 650 recipes from the kitchens of Auxiliary members edited into 100 menus by Madeline Sly (whose husband, Don, contributed the book's title), with a foreword by Marilyn Quayle, whose high visibility as Dan's wife enhances her advocacy of breast cancer education/research.

*Prescriptions* was designated a fund-raiser for cancer research from its inception during the Auxiliary presidency of Heidi Guerrero, who made sure it would make money by lining up patrons to underwrite the first printing; chief among these, says her acknowledgment, were the Prince William County Medical Society and Auxiliary and the Medical Society of Virginia. To target the grant, applications were solicited

from all three of Virginia's medical schools, and a jury of three physicians plus two Auxiliary past presidents, Mrs. Sly and Kay Reardon, brought in the verdict: the winner was Eastern Virginia Medical School, where Dr. Roger R. Perry, chief of surgical oncology, is working to develop a better staging system for determining which type of treatment a patient with breast cancer should receive and is also investigating the drug resistance that often hampers a patient's treatment when cancer recurs.

The book leads off with a section titled "VIP Friends": Nancy Reagan (cold cucumber soup), Betty Ford ("blu'bana" bread), MSV President John A. Owen, Jr. (apple pie), MSV Exec V-P James L. Moore, Jr. (brown sugar pie), and Mrs. Quayle, who contributes the menu for a "very special" meal featuring breast (what else?) of chicken stuffed with veal and a persimmon pudding she identifies as "one of my mother's . . . a special treat served to visitors at our home in Peoga, Indiana." Such personal comments flavor the entire cookbook.

The menu format makes this cookbook a rarity. What to serve for dinner? You'll find endless ideas in the section of dinner menus, and there are five other hefty sections with menu ideas for breakfast, brunch, lunch, receptions, and spe-

cial events (e.g., a tailgate party). As for the recipes, there are examples of cuisine haute enough for the spiffiest dinner party, but most of the recipes typify robust American cooking for the family table. Gail Tiesenga's corned beef hash in potato shells with tomato butter sauce illustrates the prevailing genre. So does Ginny MacIvor's sweet and savory pork pie and "Texas barbecue" as Mary Henderson makes it in Virginia.

Fish recipes abound. Shirley Hobbs' recipe for baked fish ("Frank's favorite") is the kind of classic cookery that makes a celebration of bluefish or trout. Robin Hall adds chicken, sausage, and ham to shrimp and crabmeat to create a tremendous seafood gumbo. Game is not neglected. A recipe from Carol Roper laps sauteed doves with a Madeira sauce, while Mary Lane's recipe turns a brace of ducks into a hearty stew.

To go with these entrees there are splendid salads, such as radicchio and bibb lettuce with orange vinaigrette (Carrie Chessen) and an "overnight layered" salad (Sandy Ferraraccio); succulent variations on the vegetable theme, such as tomatoes Rockefeller (Alice Imbur) and carrot souffle (Mrs. Sly); and appealing breads, among them fresh lemon muffins (Connie Horden) and cornbread revved up with jalapeno peppers (Jacquelyn Prince).

Then there are the desserts—goodies galore and all exemplifying Mrs. Sly's warning in her introduction: the menus and recipes in this cookbook should not be construed as prescriptions for those with dietary restrictions. "Fantastic!" comments Nancy Jaffe at the close of her instructions for orange bourbon cake, and to read the recipe is to believe. Similarly enticing are Charlotte Curry's Viennese chocolate bars gilded with apricot jam and Debra Brown's country pear pie.

No matter what the cookbook count is at your house, *Prescriptions* will be a welcome addition. It's a feast of ideas for great food, entertainingly presented. —A.G.

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# WHO'S WHO

From the Office of the Governor, L. Douglas Wilder, comes the announcement of the appointment to the State Board of Medicine of **Dr. Walton M. Belle**, Richmond general surgeon/gynecologist, to represent the 3rd district, and the reappointment of **Dr. Charles F. Lovell, Jr.**, internist, whose office is in Norfolk but who lives in Chesapeake, to represent the 4th district. Both men are solo practitioners.

The U.S. Army Reserve has awarded a second set of stars to **Dr. Alvin Bryant**, elevating the Hampton surgeon to the rank of major general. Deputy commander of the 310th Theater Army Area Command, a logistics unit at Fort Belvoir, Maj. Gen. Bryant has earned a brace of medals, including the Meritorious Service Medal and the U.S. Army Commendation Medal with Oak Leaf Cluster. As Dr. Bryant, he conducts a busy practice and has been chairman of the board of the Peninsula Institute for Community Health and president of the board of Newport News General Hospital, and currently serves the Riverside Regional Medical Center as chairman of its Trauma Committee. He is a 1970 graduate of Howard University, where he also did his training.

Four Medical Society of Virginia members who are on the faculty at Eastern Virginia Medical School received Dean's Faculty Achievement Awards for 1991 during ceremonies in Norfolk in May. To **Dr. James F. Lind**, chairman of the department of surgery, went the highest honor, the Dean's Outstanding Faculty Award. The other winners: **Dr. John Franklin**, director of the geriatrics program; **Dr. L. D. Britt**, chief of the division of trauma/critical care; and **Dr. Leon-Paul Georges**, director of the Diabetes Institute.

At opening ceremonies of the meeting of the American Society of Clinical Pathologists last month, **Dr. William D. Dolan, Jr.**, Arlington, received the ASCP's Distinguished Service Award Honoring Israel Davidsohn. For 44 years Dr. Dolan has been director of pathology at Arlington Hospital. He is on the faculty of his alma mater, the Georgetown University School of Medicine, and was president 1981-1983 of the American Blood Commission. He has been president also of the Arlington County Medical Society.

For **Dr. Frederick W. Parker III**, Manassas, a full-time family practice was not enough. He has been going to school part-time to get a master's degree in education, and at Virginia Tech's 119th commencement in Blacksburg this year he got it. The degree relates to Dr. Parker's long-time leadership in continuing medical education; he is currently chairman of the Prince William Hospital's

CME Committee and is a frequent presenter at educational workshops and seminars. A 1972 graduate of the George Washington University School of Medicine, Dr. Parker is a past president of the Prince William Medical Society.

The Halifax-South Boston Community Hospital honored **Dr. William Allen Fuller, Sr.**, with a reception when he retired this year after 37 years of surgical practice. Two hundred hospital employees watched as Administrator Chris Lumsden presented him with some golf clubs and a plaque citing his contributions to the hospital over the years: president of the medical staff, member of the board of directors, chief of anesthesia (1956) and surgery (1986).

Dr. Fuller's father, the late Dr. Rawley A. Fuller, also a surgeon, founded the small hospital in South Boston in 1927 that eventually became Halifax-South Boston Community Hospital. The son, too, became a medical entrepreneur: in 1961 he teamed up with **Dr. Lucien W. Roberts, Jr.**, to open the Fuller-Roberts Clinic, which today is a thriving association of ten South Boston physicians. Another generation entered the Fuller surgical tra-



**Dr. Alvin Bryant** receiving second set of stars from his wife, **Sandra**, and **Lt. Gen. James E. Thompson**.

*Photo courtesy U.S. Army Reserve*



dition when **Dr. W. Allen Fuller, Jr.**, joined his father's practice in 1978. And a second son, **Dr. R. West Fuller**, is a radiologist at Johnston-Willis Hospital in Richmond.

The senior Dr. Fuller was graduated from Washington and Lee University, studied medicine at the Medical College of Virginia (M-1946) and performed his residency at MCV and Columbia Presbyterian Medical Center, New York.

**Dr. Claiborne W. Fitchett**, professor of surgery at Eastern Virginia Medical School, has been named rector of the Medical College of Hampton Roads' board of visitors, and **Dr. T. Eugene Temple, Jr.**, Newport News, is a newly appointed member of the board.

No sooner was **Dr. Don E. Detmer**, Charlottesville, elected to the Institute of Medicine than he was made chairman of the Institute's Study on Automated Medical Records and Data and was testifying in Washington before the House Ways and Means Subcommittee on Health. At issue: physician practice guidelines as a means of cutting Medicare expenses. Dr. Detmer is vice president for health sciences and professor of surgery at UVa.

New president of the Norfolk Academy of Medicine is **Dr. George H. Christian**. Elected to serve with him as secretary was **Dr. John Brooks, Jr.**

The Portsmouth Academy of Medicine has new officers. **Dr. Kasedul Hoq** is now president, and **Dr. Sidney W. Tiesenga** is secretary.

One of the two recipients of the Roanoke College Medal in 1991 was a physician, **Dr. Harry I. Johnson**, who lives and practices in Roanoke (cardiovascular diseases) and is a Roanoke College alumnus. The award recognizes professional accomplishments and service to the community. Dr. Johnson is a graduate of the Medical College of Virginia/VCU.

At a general faculty meeting of the University of Virginia School of Medicine, **Dr. Ranes C. Chakravorty**, chief of surgical service at the Veterans Administration Center, Salem, and professor of surgery at UVa, was presented with the School of Medicine's Award for Excellence in Teaching. Dr. Chakravorty is the first member of the VA Medical Center faculty to receive the award.

In a general election, with ballot boxes at a number of businesses throughout Mathews County and the voting period from May 1-31, **Dr. Richard B. Bowles**, retired Mathews physician, fielded a majority of the 573 votes cast and thereby became honorary mayor of the 1991 Mathews Market Days Celebration. Dr. Bowles retired in 1987 after 48 years of practice in the area. He is a graduate of the University of Virginia School of Medicine and has won community service awards from both the Mathews Junior Woman's Club and the Ruritan Club.

**Dr. Jay Y. Gillenwater**, Charlottesville, was installed as the 87th president of the American Urological Association at its 1991 meeting in Toronto. He is chairman of the De-

partment of Urology at the University of Virginia.

**Dr. Thomas A. Walker**, Emporia, has been elected to a 3-year term on the board of trustees of Lynchburg College. A 1953 graduate of the college, Dr. Walker has received its T. Gibson Hobbs Memorial Award and has served on its board of overseers.

**Dr. Stephen L. Ferlazzo**, Woodbridge, is the new president of the Virginia Society of Otolaryngology/Head and Neck Surgery; members of the Virginia Society of Hematology and Oncology have elected **Dr. Michael J. Kornstein**, Richmond, as their president; **Dr. Richard W. McCallum**, Charlottesville, has commenced a term as president of the Virginia Gastroenterological Society, and **Dr. Thomas P. Davis**, Manassas, is the new president of the Virginia Academy of Family Physicians.

Two Virginia physicians appear in top spots in the roster of the American Board of Medical Specialties for 1991-1992: as president of the Board, **Dr. Peyton E. Weary**, who is chairman of the department of dermatology at the University of Virginia, and as the Board's treasurer, **Dr. Leo J. Dunn**, chairman of the department of obstetrics and gynecology at the Medical College of Virginia.

**Dr. Walter R. Zolkiwsky**, Sterling, has been named head of the board of trustees of the HCA Reston Hospital Center. A family practitioner, Dr. Zolkiwsky is a past president of the Loudoun County Medical Society.

To **Dr. Georgeanna Seegar Jones**, distaff side of the famous in vitro fertilization team at Eastern Virginia Medical School, went the Virginia Press Women's 1991 Newsmaker of the Year award. The long-time collaboration of Dr. Jones and her husband, Dr. Howard Jones, culminated in 1983 with the founding at EVMS of the Jones Institute for Reproductive Medicine.



**President for 1991-92 of the Medical Society of Virginia Auxiliary is Mrs. Phillip R. (Eileen) Thomason, Portsmouth. For a spectacular example of the Auxiliary's many good works, see page 216 of this issue.**



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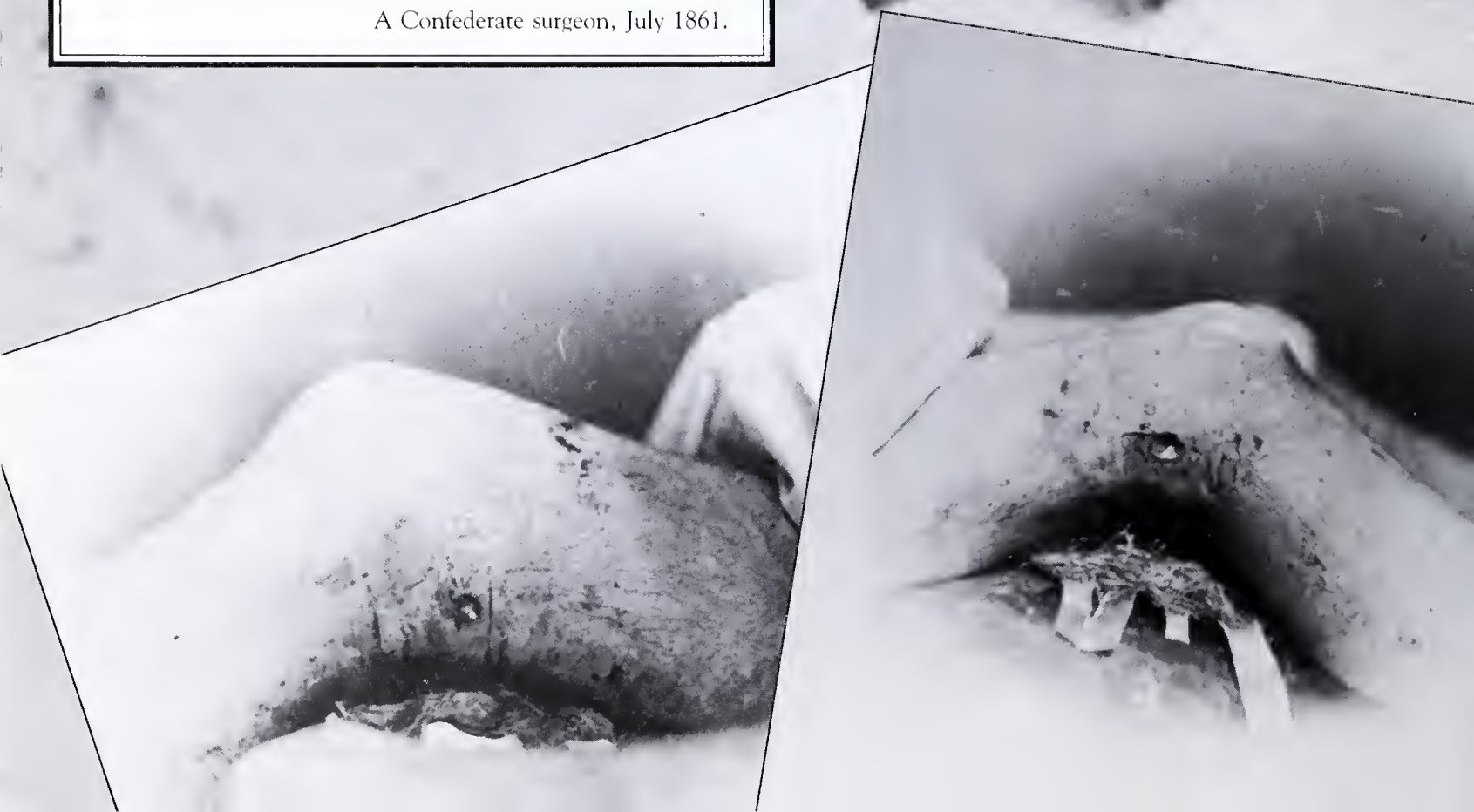


## CONFEDERATE MEDICINE: THE VIEW FROM VIRGINIA

◆ ◆ ◆

*"The whole country, from Manassas Junction to Richmond in one direction and to Lynchburg in another, was one vast Hospital, filled to repletion with the sick and wounded."*

A Confederate surgeon, July 1861.





The Civil War was a biological holocaust. Indeed, the magnitude of the carnage is unequaled in American history. It is estimated that one of every four who served died. Moreover, the 620,000 lives (360,000 Union and 260,000 Confederate) lost in this celebrated conflict nearly exceeds the total fatalities of all the nation's wars. A sizable number of fatalities (110,000 Union and 94,000 Confederate) occurred on the battlefield, but the lion's share resulted from the ravages of disease. "The victories of disease," a Confederate medical officer tellingly remarked, "exceed tenfold those of the sword." Three out of every five Union and two out of every three Confederate deaths were due to illness. In all, there were approximately 10,000,000 cases of sickness (6,000,000 Union and 4,000,000 Confederate), and every participant, northern and southern, fell ill an average of four times. Disease, disability, and death, then, were constant companions of the Civil War soldier.<sup>1</sup>

Reasons for such unparalleled carnage are the fratricidal conflict, the emotional involvement of the participants, and the state of contemporary medicine. The last named is of special significance. The nation's doctors without warning were plunged into a modern war with its unprecedented medical problems at a critical turning point in American medical history. Out of this era of transition, which saw established beliefs and practices come under increasing attack, was to emerge the beginnings of modern American laboratory medicine. In the meantime, a majority of the prevailing therapeutic measures—puking, purging, bleeding, and large doses of potentially dangerous drugs—met with little success in the day-to-day struggle against common complaints and failed miserably when confronted by yellow fever, cholera, and typhoid fever, the great killer epidemics of 19th-century America. The quality of military medicine had actually deteriorated in the half-century preced-

by James O. Breeden, PhD

*Opposite: Capt. John Brennan of Company A, 16th Virginia Volunteers, was photographed in 1864 in Harewood U.S. Army General Hospital, Washington, before his right leg was amputated. He had been shot and captured on October 27 at the Battle of Burgess Mill, near Petersburg. The Union surgeon, Dr. Reed Brockway Bontecou, used Teale's method, which preserved a long rectangular flap of muscle and integument on one side of the limb and a short rectangular flap on the other. Secondary hemorrhage, which occurred in so many Civil War amputees when infection ate through the ligatures or entered the blood stream, overtook the captain on November 25 and he died that day. A saddler by trade, Brennan had enlisted in Suffolk, Virginia, at age 27, three years before his death. Photographs and medical information courtesy of Stanley B. Burns, MD, and The Burns Archive, New York City. Brennan's earlier history courtesy of Guy Swanson, librarian, the Museum of the Confederacy, Richmond.*

ing the Civil War. This had been an era of little combat, and when war erupted in 1861 an army medical service existed more in name than in fact. The Confederacy, of course, built one from scratch. But, from an admitted modern perspective, the cruelest blow of all to the Civil War soldier was that the life-saving antiseptic management of wounds, growing out of the research of Pasteur and Lister already under way, came too late to be of help. Consequently, any serious injury to a limb, which in most instances meant amputation, raised the specter of death from one of the so-called "surgical fevers"—gangrene, erysipelas, or pyemia.<sup>2</sup>

The Civil War's toll of misery and death was most evident in the Con-

federate Army, for the southern medical officer labored under the added burden of an inadequate medical staff, near-crippling shortages of medicines and medical stores, and a steadily worsening military situation. Only rarely did he have the means necessary to perform his duties to his full professional and personal satisfaction. In recalling his practice, a Virginia medical officer remarked: "As to methods, I may say, as a general statement, that we aimed to conform to the science of the time, though the restrictions to which our ever-increasing necessities subjected us often forbade the practice of it. We did not the best we would, but the best we could."<sup>3</sup> "The pitiful aspect of Confederate medicine," George W. Adams, a modern scholar of Civil War medicine, wrote in agreement, "is that with all their limitations of knowledge, limitations common to the whole medical profession of the time, the army doctors could have saved so many more men if only circumstances had not combined against them."<sup>4</sup> Nowhere are the triumphs and tragedies of Confederate medicine better seen than in Virginia. The decision to move the Southern capital to Richmond—a mere hundred miles from the national capital—made the Old Dominion a veritable slaughter pen: almost one-third of the Confederate soldiers killed in battle died on Virginia's soil; over 400,000 Confederates were wounded in Virginia—more than in any southern state; and approximately 60% of all of the Confederate wounded passed through Virginia's hospitals.<sup>5</sup> This paper examines Confederate medicine in Virginia at its principal levels—camp and field, battlefield, and general hospital.

The principal source of disability at the outset of the hostilities was the so-called "camp diseases." Initially, the most prevalent of these were epidemics of disorders usually associated with childhood, such as measles, mumps, and chickenpox. "A



large majority of the Confederate soldiers, being from rural and up-country districts," Samuel P. Moore, the South's Surgeon General, explained, "had never had the different contagious diseases to which residents of the more populous districts are exposed . . . ; few had been vaccinated; they would, therefore, in all probability, contract these diseases, thus swelling the sick list."<sup>6</sup> It was not uncommon for entire units to be incapacitated by outbreaks of children's diseases. Howell Cobb's 16th Regiment of Georgia infantry was so badly ravaged by mumps and measles in its Richmond encampment during the summer of 1861 that it was delayed for five weeks in moving to the Peninsula.<sup>7</sup> Military operations were inevitably affected. Robert E. Lee's abortive effort to hold on to western Virginia for the Confederacy in the summer of 1861 failed in large measure because of communicable diseases. "The soldiers everywhere," Lee wrote his wife, "are sick. The measles are prevalent throughout the whole army. . . ."<sup>8</sup> This force of some 17,000, according to Surgeon Bedford Brown, a leading proponent of preventive medicine in the Confederate Army and future president of the Medical Society of Virginia, was desolated by 4,000 cases of disease and a staggering mortality.<sup>9</sup>

As immunizing attacks occurred, childhood diseases gave way to dis-

orders related to camp life—chiefly typhoid fever, malaria, and diarrhea and dysentery. Camps were notoriously filthy. A Tennessee regiment's western Virginia campsite in August 1861 was likened by its commander to "a Tennessee hog pen."<sup>10</sup> The reasons for such deplorable conditions were evident. "In the beginning, and to an unhealthy extent throughout the war," Stewart Brooks, an amateur historian of Civil War medicine, seriocomically remarked:

*Few recruits bothered to use the slit-trench latrines (and those who did usually forgot to shovel dirt over the feces) and most urinated just outside the tent—and after sundown, in the street. Garbage was everywhere, rats abounded, and dead cats and dogs turned up in the strangest places. The emanations of slaughtered cattle and kitchen offal together with the noxious effluvia from the seething latrines and infested tents produced an olfactory sensation which has yet to be duplicated in the Western Hemisphere.<sup>11</sup>*

Lax camp discipline and the failure of Confederate officers to appreciate the importance of sanitary rules made matters worse. The disposal of fecal waste was a persistent problem. "On rolling up my bed this morning," a Virginia private wrote in his diary in December 1863, "I found I had been lying in—I won't say what—something though that didn't smell like milk and peaches."<sup>12</sup> A growing awareness on the part of Confederate authorities of the lack of proper camp sanitation and its disastrous effects on health led to increasingly strict directives aimed at reform. The Surgeon General ordered "frequent inspections" and monthly sanitary reports. Illustrative of compliance, the regimental commanders of a brigade of the Army of Northern Virginia were ordered in August 1862 to publish and enforce all sanitary regulations. Latrines were to be dug immediately, and armed guards were to ensure their use. Those who disobeyed were to be "severely punished." A patrol was instituted "to prevent the commission of nuisances within the

camps."<sup>13</sup>

Diet was a further source of "camp diseases." The availability of food was not a problem in the early days of the war, but the preparation of it was. "The undisciplined Confederate," Bedford Brown observed, "naturally sought the quickest and readiest method of cooking his meals, and that was by the frying pan. This culinary instrument cost the Confederate Army a vast amount of invalidism and indirectly many lives. It would ruin any army."<sup>14</sup> Herbert M. Nash, a surgeon with an unidentified Virginia regiment, maneuvered across a muddy field between the lines during the Seven Days campaign to treat two soldiers on picket duty who reportedly had been poisoned. The culprit, he found, was a freshly varnished spade on which they had been frying their food.<sup>15</sup> "Not until the Confederate soldier substituted the stewpan for the frying pan in preparing his food," Wyndham B. Blanton, the well-known historian of medicine in Virginia, asserted, "did his health improve."<sup>16</sup> But even then, dietary disorders, chiefly indigestion, colic, diarrhea, and scurvy, accompanied the deterioration of the Confederate ration in the later stages of the conflict.

Despite reform efforts of all types, camp diseases remained a problem throughout the hostilities. Their cost, according to Paul E. Steiner, a student of the Civil War's biological toll, was measured in "reduced military efficiency" because of these disorders' "high morbidity, considerable mortality, and protracted course."<sup>17</sup> Indeed, it was no accident that the southern soldier was far more healthy on the march than he was in camp. Stonewall Jackson's famed brigade was an excellent case in point. "Though almost constantly in motion, subjected to all the hardships, exposure, privations, and fatigue incident to long and forced marches," Bedford Brown asserted, "[it] presented the smallest sick list and bills of mortality of any corps in the Confederate Army."<sup>18</sup>

Deployed against the incursions of

#### ABOUT THE AUTHOR

James O. Breeden is Professor of History at Southern Methodist University, Dallas TX 75275-0176, and is well-known to historians all over the country as a writer, editor, and lecturer in his research specialty, the history of the South, particularly Southern science and medicine. He was born in Morrisville, Virginia, and took both BA (1959) and MA (1961) at the University of Virginia before going on to Tulane for his PhD (1967). Professor Breeden presented this article as a public lecture on January 11, 1991, in Richmond at Battle Abbey, headquarters of the Virginia Historical Society, in conjunction with the Society's exhibit, "Fevers, Agues, and Cures: Medical Life in Old Virginia."



the diseases in the camp and field were the regimental medical officers—a surgeon and an assistant surgeon. William Taylor, an assistant surgeon with the 19th Virginia Regiment wrote of his practice:

*In one pocket of my trousers I had a ball of blue mass [a mercurial preparation], in another a ball of opium. All complaints were asked the same question, "How are your bowels?" If they were open, I administered a plug of opium; if they were shut, I gave a plug of blue mass.<sup>19</sup>*

The true test of Confederate medicine, however, was the battlefield. A more challenging arena could not have been found. "For my own part," Taylor exclaimed, "I freely admit that I was never in a battle but that I should have felt the most exultant joy had I been out of it."<sup>20</sup> Armed with a few essentials—a pocket case of surgical instruments, ligatures, tourniquets, bandages, lint, splints, and a pain-killer, sometimes morphine or opium, but often whiskey or brandy—the assistant surgeon advanced with the troops. As they moved into position, he noted likely locations for forward aid stations. Any cover—trees, fences, haystacks, depressions in the earth, and gullies in particular—were committed to memory. The assistant surgeon shifted positions as the battle unfolded. Assisted by the infirmiry corps, he provided first aid: usually, the administration of a stimulant—probably whiskey ("Our most valued medicament," Taylor exclaimed)—and preliminary bandaging to protect the wound, followed by transfer to the field hospital.<sup>21</sup>

Casualties were evacuated in rude ambulances. In the opening days of the war some spring conveyances had been available, but these soon gave way to common farm wagons which severely jolted the wounded as they were drawn by mules through uneven, often wooded terrain or on roads badly rutted by artillery and supply trains. "These ambulances," William Taylor recalled, "were very sad-looking and,

for the most part, very uncomfortable vehicles, and their unfortunate passengers were apt to have a dreary ride of it."<sup>22</sup> Inclement weather and inconsiderate drivers added to the occupants' misery. Understandably, the wounded, when able to, often preferred to walk from the battlefield to the field hospital. Casualties in the Army of Northern Virginia showered praise on the Richmond Ambulance Corps. This volunteer organization, formed in the spring of 1862, was made up of men exempt from military duty, and evacuated the wounded at its own expense. It performed its mission of mercy in nearly every engagement in which Lee's army was involved.<sup>23</sup>

The field hospital, where the regimental surgeons waited, was usually two or three miles to the rear of the battle lines. In reality, it bore little resemblance to a hospital. "To apply the term hospital to this field station," an assistant surgeon exclaimed, "is really a misnomer."<sup>24</sup> The one at Second Manassas in which Simon Baruch, an 1862 graduate of the Medical College of Virginia, performed his first military surgery was described as "a small house . . . in which an operating table was extemporized, by laying a door upon a barrel and a box."<sup>25</sup> The aid was not much more promising than the setting. Triage was hurriedly done. Casualties were classified as mortally wounded, slightly wounded, and in need of surgery. The doomed were made as comfortable as possible and left alone to die. Those with minor wounds had their injuries dressed, usually with cotton lint dipped into cold water, and were perhaps given whiskey or an opiate. It was the surgical cases that dominated activity at the field hospital. These unfortunates faced what in recent wars has been called "meat ball surgery."

"The hard-pressed surgeon," James I. Robertson, Jr., the prominent Virginia historian of the Civil War, wrote, "performed his basic tasks: He did what he could to control any serious hemorrhaging; he probed the wound to locate and re-

move the bullet and any foreign objects; and, in many cases, he performed an amputation."<sup>26</sup> (Although discussed in the context of the general hospital, the bulk of military surgery on both sides was performed in the field.) One shocked visitor likened the scene to a "butcher's shamble."<sup>27</sup> A moving description of a field hospital has been left by W. W. Blackford, an officer in J. E. B. Stuart's command.

*Along a shady little valley . . . the surgeons had been plying their vocation all the morning upon the wounded. Tables about breast high had been erected upon which screaming victims were having legs and arms cut off. The surgeons and their assistants, stripped to the waist and all bespattered with blood, stood around, some holding the poor fellows while others cut and sawed with a frightful rapidity, throwing the mangled limbs on a pile nearby as soon as removed. Many were stretched on the ground awaiting their turn, many more were arriving continually, either limping along or borne on stretchers, while those upon whom operations had already been performed calmly fanned the flies from their wounds. But among these last, alas! some moved not—for them the surgeon's skill had not availed. The battle roared in front—a sound calculated to arouse the sublimest emotions in the breast of the soldier, but the prayers, the curses, the screams, the blood, the flies, the sickening stench of this horrid little valley were too much for the stomachs of the men, and all along the column, leaning over the pommels of their saddles, they could be seen in ecstasies of protest.<sup>28</sup>*

Such scenes were magnified during extended or hotly contested engagements, where casualties not infrequently swamped the field hospitals. Describing the scene at Second Manassas, Spencer Welch, assistant surgeon of the 13th South Carolina Regiment, wrote: "I saw large numbers of wounded lying on the ground as thick as a drove of hogs in a lot."<sup>29</sup>

The chronically sick and seriously wounded were sent to rear area "general" hospitals (so named because admission was not limited to the troops of particular units or



states). Because of its "short war" mentality and the monopolizing demands of military mobilization, Confederate authorities initially rejected an extensive plan of hospital accommodations, according to Surgeon General Moore, as "wholly unnecessary."<sup>30</sup> Predictably, the ensuing epidemics of camp diseases and the heavy casualties from the opening campaigns nearly overwhelmed the fledgling Confederate Medical Service. The wounded from the battle of First Manassas streamed into Richmond. Within two weeks there were 4,000 patients to be cared for. Hospitals, already crowded with the victims of communicable disorders, could accommodate only a fraction of this number, forcing the Medical Department to scramble to find space for the rest. Warehouses, barns, hotels, churches, stores, and private homes were converted into temporary hospitals. There was, an English observer wrote, hardly "a gentleman in or about Richmond who had not from one to four patients in his house."<sup>31</sup>

The Confederacy's hospital problem sparked a concerted effort to construct suitable facilities. The pavilion plan, suggested by British hospital design in the Crimean War, was adopted and improved upon by the Surgeon General. Its central feature was detached wards—measuring 100 feet by 30 feet and one story in construction. Every building, according to Moore, was "to be a ward and . . . of undressed plank set upright, calculated for thirty-two beds, with streets running each way, say thirty feet wide. From fifteen to twenty of such wards constituted a division, three or more divisions making a general hospital."

By the end of 1861, five of these general hospitals had been constructed in the suburbs of Richmond. Each could accommodate roughly 20,000 patients at a time. Moreover, the ward concept allowed the segregation of the sick and wounded. Moore was pleased with

these facilities and temporary ones, with the exception of the largest warehouses and factories, were gradually abandoned. Sadly, owing in large part to the Confederate bureaucracy and red tape (principally the requirement that the Medical Department had to depend upon the Quartermaster and Commissary departments to erect and furnish them), hospital construction in the Confederacy, failed to keep pace with the ever growing need.<sup>32</sup> But steady progress was made in the organization of a system of general hospitals: more and better facilities were evident; the myriad of small hospitals—those with a capacity of less than one hundred patients—were gradually closed as these new ones came on line; the War Department exhibited a growing appreciation for the Medical Department; hospital appropriations grew; and supportive, even farsighted, legislation was adopted by the Confederate Congress.<sup>33</sup> Once it had been established, the Confederate general hospital system proved remarkably successful, supplying the sick and wounded to the very end, in the words of H. H. Cunningham, the leading authority on Confederate medicine, "with satisfactory hospital accommodations."<sup>34</sup>

The mature general hospital system is best seen in Richmond, the chief medical center of the Confederacy. Within a year of the outbreak of hostilities, this city of 40,000 contained approximately 20,000 hospital beds. By war's end 15 named and 27 numbered hospitals were established here.<sup>35</sup> Under the watchful eye of Surgeon General Moore, they were impressive for their construction, capacity, and overall management. "In the East," Courtney R. Hall, an early student of Confederate medicine wrote, "the effort after every campaign, was to get the severely wounded quickly to Richmond if possible, where they would receive the best care in the best-equipped and most permanent of the Surgeon General's organizations."<sup>36</sup>

The largest of Richmond's hospitals—and the most extensive mili-

tary hospital in American history to that time—was Chimborazo. Named for the heights overlooking the James that it occupied, this celebrated Confederate hospital, which opened on October 11, 1861, was ideally located, with an abundance of good water, excellent drainage, and a bountiful supply of fresh air. Chimborazo consisted of 150 well-ventilated, pavilion-type buildings with an 8,000-bed capacity. An additional 800 to 1,000 convalescents could be provided for in tents. The facility was under the command of Dr. James B. McCaw, the prominent Richmond physician-teacher-editor. His medical staff consisted of 50 surgeons, two apothecaries, and 45 hospital matrons. Designated an independent army post by the Secretary of War, Chimborazo was largely self-sufficient. It had five icehouses, a Russian bathhouse, five soup houses, a bakery with a daily capacity of 10,000 loaves of bread, and a large brewery; hundreds of head of livestock and large numbers of poultry were kept on a neighboring plantation; and a hospital-operated trading boat plied the James River and the Kanawha Canal as far as Lynchburg and Lexington, bartering for provisions. Chimborazo remained in continuous operation until the evacuation of Richmond in April 1865. During its 3½-year history, this hospital treated approximately 77,000 patients (63,000 cases of disease and 14,000 wounded). Deaths numbered only 7,000, or slightly more than nine percent.<sup>37</sup>

The large, fixed general hospital, like Chimborazo, offers the fullest picture of Confederate medicine. Disease in all its principal forms preyed upon the Confederate soldier. A group of Virginia general hospitals, which between September and December 1862 reported 35,000 cases of specific diseases in 48,544 admissions, points up the magnitude of the problem.<sup>38</sup> Camp diseases, as aforementioned, were the principal early cause of morbidity. The most dangerous of



these were measles and smallpox. Measles has been called "the scourge of the Confederate Army." "The diseases consequent to and traceable to measles," Bedford Brown contended, "cost the Confederate Army the lives of more men and a greater amount of invalidism than all other causes combined."<sup>39</sup> In the early days of the war, the disorder was so prevalent in the newly formed units from the country that it is said to have greatly impeded their organization. On occasion, entire regiments had to be disbanded temporarily. One camp reported 4,000 cases of measles among 10,000 recruits. And during the summer of 1861, one in every seven men in the Army of the Potomac, the forerunner of the Army of Northern Virginia, was attacked.<sup>40</sup>

This large southern army is also an informative lens for viewing the ravages of smallpox. An epidemic following upon the heels of the Antietam campaign crowded Virginia hospitals and took many lives. During a single week in December 1862, Richmond's Smallpox Hospital, created specifically for the treatment of smallpox patients, sustained 110 deaths out of 250 admissions.<sup>41</sup> A second epidemic swept through the Army of Northern Virginia in the winter of 1863-64. As before, the disease exacted a heavy toll in lives. From October 1, 1862, to January 31, 1864, a period embracing both epidemics, Virginia's general hospitals treated 2,513 smallpox cases with 1,020 deaths. (In addition, 1,196 cases of varioloid were reported with 39 deaths.)<sup>42</sup> Medical authorities tried to stem the threat of smallpox in various ways, including compulsory vaccination, the restriction of soldiers to camp in infected areas, a 15-day quarantine for sick and wounded during outbreaks of the disease, and the isolation of those stricken in special hospitals or remote buildings and tents.<sup>43</sup>

As the war progressed, typhoid fever, malaria, and diarrhea and dysentery became the great causes of morbidity among Confederate troops. Typhoid fever, an age-old bane of

armies, struck early and hard. Surgeon Joseph Jones, perhaps the leading authority on health conditions in the large southern armies, general hospitals and prisons, estimated that it was responsible for at least one-fourth of the Confederate fatalities between January 1, 1862, and August 1, 1863.<sup>44</sup> Such seems to have been the case in Virginia. An epidemic in the summer and fall of 1861 exacted a heavy toll. Between July 1, 1861, and March 31, 1862, the Army of the Potomac, reported 1,133 typhoid cases, roughly 23 cases per thousand strength. From January 1862 to February 1863, Virginia's general hospitals outside of Richmond treated 6,245 typhoid cases with 1,619 deaths.<sup>45</sup> Because the disorder was so little understood, uncertainty characterized its treatment.<sup>46</sup> Fortunately, like children's diseases, typhoid usually affects an individual but once during life and, as Jones pointed out, it "progressively diminished during the progress of the war and disappeared almost entirely from the veteran armies."<sup>47</sup> Its history in the Charlottesville General Hospital, one of Virginia's principal Confederate hospitals, is instructive: 1,297 cases and 312 deaths during the period July 1861-August 1863 were attributed to typhoid fever, as compared with 132 cases and 45 deaths during the months September 1863-February 1865.<sup>48</sup>

Malaria was a persistent medical problem in the large Confederate armies. Long endemic and often epidemic in the southern states, this disorder had showed signs of declining in the decade preceding the war, but during the hostilities it soared to record levels. One malariologist linked the disease's resurgence to troop movements in the region, arguing that they "must have profoundly disturbed the balance between infection and resistance."<sup>49</sup> Whatever the reason, malaria accounted for one in every seven cases of disease among Confederate troops east of the Mississippi from 1861 to 1862. During the ten months January-October 1862, the Confed-

erate Army of the Valley of Virginia, with an average strength of 15,582, reported 3,385 cases.<sup>50</sup> Despite its prevalence, malaria caused relatively few deaths, a fact attributable to the likelihood of some degree of immunity the region's long history with the disease bestowed and the use of quinine, when available, as a specific and prophylactic to control it.<sup>51</sup>

Diarrhea and dysentery were the great enervating ailments of the Civil War. Their incidence in the Confederate armies was roughly two times as great as it was in those of the Union, reducing considerably the effectiveness of the already numerically inferior southern forces.<sup>52</sup> "Chronic diarrhea and dysentery," Joseph Jones held, "were the most abundant and most difficult to cure amongst army diseases, and whilst the most fatal diseases, as typhoid fever, progressively diminished, chronic diarrhea and dysentery progressively increased, and not only destroyed more soldiers than gunshot wounds, but more soldiers were permanently disabled and lost to the services from these diseases than from the disability following the accidents of battle."<sup>53</sup> Nine-tenths of all recruits, one medical officer claimed, were stricken with diarrhea. "Whatever else a patient had," another asserted, "he had diarrhea."<sup>54</sup> "Virginia quickstep" as these conditions were often called, accounted for almost one-fourth (226,828 of 848,555) of the cases of disease reported from the field in the Confederate forces east of the Mississippi during the first two years of the war. Between July 1861 and March 1862 the Confederate Army of the Potomac, with an average mean strength of 49,394, reported 36,572 casualties from diarrhea and dysentery.<sup>55</sup> Since few of its victims were sent to the hospital, it is highly telling that diarrhea was the most common disease at Chimborazo (10,503 cases). Diarrhea and dysentery were also the principal source of morbidity in the Charlottesville General Hospital (2,172 cases).<sup>56</sup> Medical officers were in general agree-



ment on the significance of an inadequate diet, poorly prepared food, impure water, exposure, and fatigue in the onset of intestinal disorders. Yet they were sharply divided on treatment. Most continued to rely on the long standing practice of combating loose bowels with liberal doses of mineral and botanic astringents. The best results, however, were achieved through a regimen of proper diet and rest.<sup>57</sup>

The treatment of trauma—and bullet wounds in particular—made up much of the practice of the Civil War medical officer. The number of northern wounded is placed between 275,175 and 400,000. Similar figures for the South are not available, but a conservative estimate of at least one-half (137,583 to 200,000) of the Union totals seems acceptable. Most combat-related injuries—estimated at 94% of the total—were inflicted by the conoidal minie ball. The destructiveness of this bullet was the result of its size (.58 caliber), soft lead composition, and low velocity. On impact, it tumbled or flattened, producing a savage, bursting wound. Bony structures sustained extensive fissuring and comminution. “The shattering, splintering, and splitting of a long bone by the impact of a minie . . . ball,” as one surgeon graphically put it, “[was] in many instances, both remarkable and frightening.”<sup>58</sup> Moreover, owing to its low velocity, the minie ball carried bits of clothing and skin and other foreign material into the injured tissue, virtually assuring an infected wound.

Battlefield casualties presented a wide spectrum of trauma. In general, injuries fell into three broad categories: severe flesh wounds, broken bones, and penetration of vital organs. The authoritative *Manual of Military Surgery*, prepared in 1863 by order of the Surgeon General, provides informative statistics on Confederate casualties. Wounds of the abdomen were relatively infrequent—less than 5% of the total—

but they constituted an almost certain death sentence. Chest wounds accounted for 19%. Head and neck wounds made up 12%. But it was injuries of the extremities, an estimated 65% of the wounded, that dominated casualty lists.<sup>59</sup>

Early experience taught surgeons that amputation of an injured limb was the only means of saving life. These empirical observations seemed to reinforce the findings of British surgeons in the Crimean War, where it had been concluded that under existing methods of treatment the wounding of any joint or the shattering of a long bone by a gunshot usually proved fatal.<sup>60</sup> Consequently, amputation for both—and the sooner the better—became the rule of thumb, and thousands of southern soldiers suffered indescribable agony and risked death from secondary infection owing to this practice.<sup>61</sup> The Seven Days’ Campaign is revealing. During this extended engagement, Richmond hospitals reported 132 amputations of the leg (43% mortality), 172 of the thigh (49% mortality), 192 of the arm (28% mortality), and 45 of the forearm (13% mortality). But these mortality rates reflected the experience of the best hospitals in the Confederacy and, as one surgeon reminded, “gives far more favorable results than have been obtained elsewhere.”<sup>62</sup> The well-known shortage, and at times absence, of anesthesia compounded the terror of the operating table. At Second Manassas, Spencer Welch assisted in the amputation of an acquaintance’s arm without anesthesia; he held the artery while the regimental surgeon cut off the shattered limb.<sup>63</sup>

Reportedly, three out of every four Civil War operations were amputations. By 1864, there were nearly 10,000 amputees in the Confederacy. Such a drastic practice on so large a scale moved Courtney R. Hall to characterize wartime surgery as “resembling actual butchery.”<sup>64</sup> The prevalence of primary amputation did not go unchallenged, as further observation was to lead to a conservative reaction. One of the

most outspoken opponents of the ready removal of damaged limbs was James Bolton, the surgeon-in-charge of Howard’s Grove Hospital in Richmond. “Amputation,” he asserted, “is only an exchange of risk of death by exhaustion for risk of death by shock.” In 1864, he devised an ingenious form of bone fixation in fractures, the forerunner of the modern Anderson apparatus, that preserved length and alignment in surgically repaired extremities and encouraged operative procedures as an alternative to amputation.<sup>65</sup>

Civil War surgery of all types was often followed by dangerous and frequently fatal secondary infections. The reasons are readily discernible. “The Civil War,” George W. Adams has written, “was fought in the very last years of the medical middle ages. While the guns were firing throughout the South, Pasteur was laying the ground work for bacteriology, and within two years after the surrender of Lee, Lister was beginning the application of his aseptic method.” Meantime, the old, tragic, practices continued to prevail:

*The surgeons of the day were still in the period of “laudable pus.” They believed that supuration was a normal and necessary part of the mechanism of tissue repair and were astonished when in a few cases wounds healed without it. They thought a bare finger was the best probe; they operated in dirty uniforms; they used the same marine sponge to swab out the wounds of countless men; they re-used linen dressings; they meddled with wounds and thus made bad matters worse. If a knife dropped to the floor during an operation they would pick it up, rinse it in tap water, and continue the operation.*

“Far from being surprised at their large mortalities,” Adams asserted, “we should marvel that a majority of their operation cases recovered.”<sup>66</sup> In addition, hospitals were often as unsanitary as camps. The inspection report of a Petersburg hospital in 1864 charged “inexcusable neglect”:

*The police was very bad. In fact, no attention seemed to be paid to cleaning up the grounds immediately in and about*



*the hospital, nor was proper attention bestowed upon the sinks [latrines]. The ground between the hospital and the sinks had been used for uncleanly purposes by the patients, making it offensive to sight as well as smell.*<sup>67</sup>

The principal “surgical fevers,” as secondary infections were called, were erysipelas, pyemia, and gangrene. Although serious hazards in all Confederate general hospitals, their true impact is impossible to assess for two principal reasons. First, none of these conditions were found in the Confederate table of diseases before the middle of 1864. Second, in many instances when a secondary infection supervened no change was made in diagnosis. Thus it was common for deaths from gangrene to appear on the hospital records as due to gunshot wounds. Unquestionably, gangrene (*phagedaena gangrenosa*) was the most dangerous of the supervening infections and it became one of the Civil War’s most serious medical problems. Joseph Jones found what he considered to be the Confederacy’s first cases among the medical records for Stonewall Jackson’s wounded who were treated in the Charlottesville General Hospital following the battle of Port Republic, Virginia, in June 1862. Thereafter this “disease” progressively increased, although no case was officially recorded until July 1863—more than a year after its initial appearance.<sup>68</sup>

The onset and progress of gangrene were poignantly described by Edward D. Warren, the author of a popular Confederate manual of surgery who served as a surgeon in the Charlottesville General Hospital before becoming Surgeon General of North Carolina. “The symptoms,” he wrote, “were feverishness, loss of appetite, sleeplessness, coated tongue, and deranged bowels, followed by a dry and painful condition of the wound; the appearance of an ash-colored slough, soft and pulpy; engorgement of the neighboring skin with eversion and undermining the wound edges—being of a livid red color—; and, finally, the complete breaking down of the dying tissue,

with the development of a thick and dirty fluid with a peculiarly offensive odor. The mortification extended rapidly and the system sank under its baneful influence.”<sup>69</sup>

Gangrene cases were treated through constitutional and local therapies. The former, consisting of a nutritious diet and combinations of tonics and anodynes, was designed to bolster the patient’s physical and emotional state. The latter, ranging from additional surgery to the application of various preparations and agents to the wound (Jones recommended “concentrated fuming nitric acid”!), was aimed at destroying the poison and diseased tissue and promoting healthy granulation. Like smallpox victims, gangrene patients were often segregated in hopes of preventing the spread of the disease.<sup>70</sup>

The women of the South were invaluable in the care of the sick and wounded in the Confederacy’s hospitals. Most served as voluntary nurses or paid hospital matrons. Phoebe Yates Pember, the Charleston native who served as a matron for one of the divisions of Chimborazo, is illustrative.<sup>71</sup> But Virginia’s foremost female medical service figure was Sally L. Tompkins. The member of a prominent and wealthy Virginia family, Tompkins established a hospital in the Richmond home of Judge John Robertson ten days after First Manassas. She operated it at her own expense. Within weeks, the 22-bed facility was endangered when Surgeon General Moore ordered the closing of the smaller and private hospitals in the Confederate capital. The Robertson Hospital was allowed to remain open, however, when Tompkins confronted Confederate authorities with proof of its impressive record in returning patients to duty. To comply with the statutory provision that every hospital was to be headed by a Confederate officer, Jefferson Davis commissioned Tompkins a captain. She accepted the commission (the only one granted to a woman in the Confederacy) but refused to take any salary. The Robertson Hospital

remained in operation until July 1865. It cared for 1,333 patients with but 73 deaths.<sup>72</sup>

The southern surgeon, whether in the field or the hospital, was at a great and growing disadvantage in the effort to perform his duties. The problems that threatened his effectiveness were legion. The most basic of these was a chronic and extreme shortage of trained physicians. Each regiment was authorized a surgeon and an assistant surgeon and each general hospital a surgeon-in-charge and one medical officer or contract (civilian) physician for every 70 or 80 patients. From the outset of the hostilities this was seldom the case. As early as the summer of 1862, the head of a Petersburg general hospital reported that he and a single assistant were caring for 400 patients.<sup>73</sup> A major obstacle was the fiery patriotism of the South’s doctors, many of whom initially put aside their professional training for active duty. E. A. Craighill, a native of Charles Town (now West Virginia) and a March 1861 graduate of the medical department of the University of Pennsylvania, served as a private in the 2nd Virginia Infantry, part of the Stonewall Brigade, before accepting a surgeon’s commission after First Manassas. And James B. McCaw, the celebrated head of Chimborazo Hospital, was about to leave for active duty with a cavalry troop when Surgeon General Samuel P. Moore persuaded him not to abandon his profession.<sup>74</sup> Ultimately, an estimated 3,400 physicians served in the Confederate Medical Service, while its Union counterpart enrolled 11,700, or approximately one doctor for every 133 northern soldiers and one for every 324 southern ones. Virginia furnished nearly 800 medical officers to the Confederacy.<sup>75</sup>

There were also inhibiting shortages of medicines, medical stores, and instruments. Even when needed items were to be had, the woefully inadequate southern transportation system and the involved Confederate logistics procedures made them



virtually inaccessible. Therefore, southern surgeons were frequently forced to find substitutes or do without. The medical officer's meager supply of essential medicines and instruments made him, in the words of Hunter Holmes McGuire, one of the Confederacy's most famous medical officers, "fertile in expedients of every kind."

*I have seen him search field and forest for plants and flowers whose medicinal virtues he understood and could use. The pliant bark of a tree made for him a good tourniquet; the juice of the green persimmon, a styptic; a knitting-needle, with its point sharply bent, a tenaculum; a pen-knife, in his hand, a scapel and bistoury. I have seen him break off one prong of a common table fork, bend the point of the other prong, and with it elevate the bone in depressed fracture of the skull, and save life. Long before he knew the use of the porcelain-tipped probe for finding bullets, I have seen him use a piece of soft pine wood, and bring it out of the wound marked by the leaden ball.*<sup>76</sup>

In spite of such seeming heroics, the Confederate Medical Service was controversial. (So, too, was that of the Union.) Charges of ignorance and inefficiency, Cunningham notes, were rife throughout the conflict. Typically, the hospital steward of the 24th Virginia Regiment labeled the regimental surgeon "a great humbug."<sup>77</sup> Without doubt, many of the sources of concern—the lack of proper care and soaring death rates, most notably—were in large part attributable to the state of medicine and the circumstances of a Confederate practice. Moreover, most complaints were lodged in the wake of major battles when medical services were taxed to their fullest. But that incompetents found their way into Confederate physician ranks and careless, even cruel, acts were committed cannot be denied. As a group, however, the Confederacy's military doctors were competent, conscientious, and courageous, and for every act of neglect there were hundreds of dedication and self-sacrifice. Simply stated, the hostilities transformed the isolated southern general practitioner into an able military surgeon.

"The hardships he endured and the privations to which he was subjected," as Hunter McGuire put it, "soon transformed him from a novice to a veteran; and I can say with truth that, before the war ended, some of the best military surgeons in the world could be found in the Confederate Army."<sup>78</sup> Modern support for this perspective has come from Courtney R. Hall, who movingly observed: "If, as has been said, Stonewall Jackson was the strong right arm of the high command and Jeb Stuart its keen eye, it may be equally true that the medical department provided the means and skill by which not only the arms and eyes, but the entire Confederate organism continued to function."<sup>79</sup>

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# Pneumoperitoneum and Portal Venous Air After Barium Enema

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**O**VER three million barium enema examinations are performed annually in the United States. Among the complications of the study are perforations, extravasation, and pneumatosis coli. Portal venous air is a rare complication usually encountered with inflammatory bowel disease. We wish to report a case in which the patient had not only portal venous air but pneumoperitoneum following a high density barium enema with air contrast.<sup>1</sup>

## Case Report

A 39-year-old male was referred for an air contrast barium enema by his family physician. The patient was in good health until four months prior to the barium enema when he developed abdominal pain and diarrhea, with occasional blood. He was seen by a gastroenterologist who performed colonoscopy to a level of 76 cm and identified mucosal ulcerations. A mucosal biopsy revealed mild chronic inflammatory changes. The patient was treated with a 10-day course of metronidazole and psyllium hydrophilic mucilloid with improvement of his diarrhea. He did not return to his gastroenterologist, but 3½ weeks prior to the barium enema he again became symptomatic with diarrhea and abdominal pain and noted occasional rectal bleeding. His family physician started treatment with operamide HCl and referred him for an air contrast barium enema.

As the rectal cuff was inflated, the patient experienced considerable rectal pain and the cuff was only partially inflated to approximately half its normal diameter. The patient continued to complain of discomfort but elected to continue the study. Barium was administered to the level of the splenic flexure, and air insufflation begun. With the colon only partially distended with air, the patient expelled the partially inflated retention cuff. Blood was noted mixed in the barium. Overhead films obtained demonstrated an incompletely distended colon with reflux of barium into the terminal ileum. Most noteworthy was air in the hepatic portal venous radicles and free intraperi-

toneal air, the latter documented on an erect chest radiograph (Fig. 1). A lateral view of the rectum failed to reveal any evidence of retroperitoneal or intramural air that might suggest a rectal tear caused by the retention cuff. The patient's blood pressure was 160/90 mm Hg and pulse 84/min and regular; he was in no apparent distress.

The patient was admitted to the hospital on the surgical service. On physical examination, tenderness was elicited in the left lower quadrant without rebound, guarding or rigidity.

Laboratory examination revealed a leukocyte count of 7600 white blood cells per cubic millimeter with a hemoglobin of 15 grams and a hematocrit of 43 percent. The differential and platelet count were normal. The patient was started on high doses of antibiotics and an exploratory laparotomy was performed. At surgery emphysema was evident within the transverse mesocolon with no evidence of barium or fecal material outside of the colon or in the peritoneal cavity. A perforation was not identified. An ascending and transverse colectomy was performed with an ileocolostomy.

At pathology the gross specimen of the colon showed numerous superficial ulcerations with thickening of the mucosa and submucosa due to edema and induration. The mucosa was coated by a thin layer of barium with some liquid barium evident within the lumen. Numerous enlarged lymph nodes were evident in the mesocolon measuring up to 12 mm in diameter. A site of perforation was not identified.

At microscopic examination extensive superficial mucosal ulcerations were noted with the ulcers covered by necrotic debris and polymorphonuclear leukocytes. Multiple crypt abscesses were present. The final diagnosis was ulcerative colitis with regional lymph nodes showing evidence of chronic lymphadenitis.

## Discussion

Portal venous air has been described in association with inflammatory bowel disease, following rectal balloon catheters, and with diverticulosis. The mechanism is thought to be due to a tear in the mucosa, allowing intramural dissection of gas but too small to permit entry of barium. Although hepatic portal venous gas in patients with bowel infarctions, sepsis, and necrotizing enterocolitis can be an ominous finding, it has become apparent that there are situations where this finding is more innocuous. Katz et al have recommended treating patients with hepatic portal venous gas following an air contrast barium enema conservatively and administering antibiotics only to those patients with bacteremic symptoms.<sup>2</sup>

Intraperitoneal perforations have been divided into those with pneumoperitoneum without and with spillage of barium. With those who do not spill barium, the leak is presumably smaller and less likely to produce fecal contamination.<sup>3</sup> The likelihood of perforation is

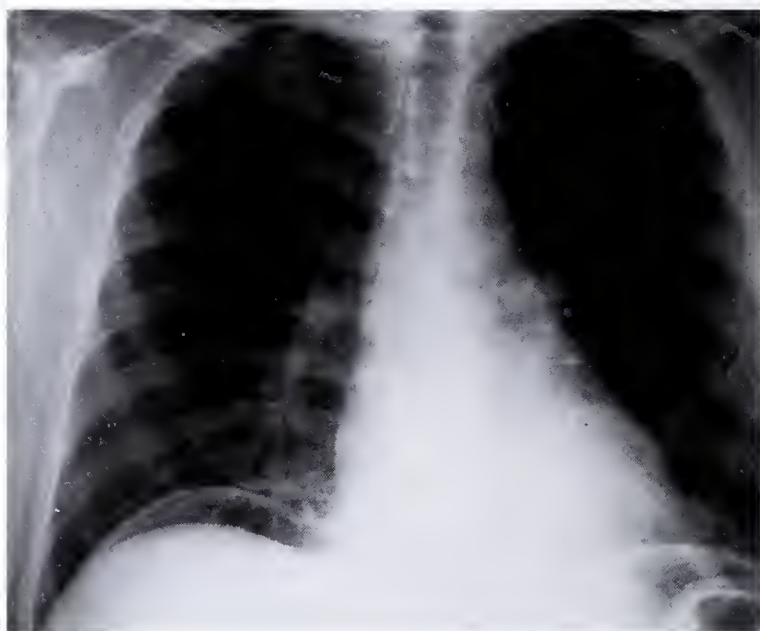
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Submitted 2-4-91.





Fig. 1. A (above left), preliminary film. B (above right), PA view with barium and air in colon. Air present in intrahepatic portal venous radicles. Thickened walls of transverse colon outlined by free intraperitoneal air. C (right), erect PA view of chest following double contrast barium enema demonstrating free subdiaphragmatic air.



increased by certain underlying diseases, particularly diverticulitis, carcinoma and inflammatory bowel disease. Ansell reported an incidence of perforation approximating one in 12,000 examinations.<sup>4</sup> A review by Nelson et al studied 42,000 barium enemas with seven perforations and no survivors.<sup>5</sup> In his review of pneumoperitoneum secondary to air contrast barium enemas, Winfield found one series of more than 10,000 studies performed within a five-year period with two perforations documented, neither of which required surgical therapy or produced serious symptomology. He was only able to find two other cases of isolated pneumoperitoneum secondary to air contrast barium enema and added a third case of his own. He concluded that perforation of the colon during air insufflation is a relative rarity.<sup>3</sup> Nelson et al noted a high incidence of transverse colon perforations in elderly men in whom there was no apparent colonic disease. No definite explanation was found; it was postulated that segmental ischemia of the transverse colon may lower the bursting pressure significantly. Han and Tishler found that perforations above the peritoneal reflection do not appear to be related to technical factors, making them difficult to predict or prevent.<sup>6</sup> Chong et al described a patient with pneumoperitoneum, omental emphysema and intramural barium perforation following a double contrast barium enema. Like our case, their patient had undiagnosed ulcer-

ative colitis and the perforation occurred in the transverse colon.<sup>7</sup>

Our patient is unusual in that both pneumoperitoneum and portal venous gas were discovered following the air contrast study, without extravasation of barium. No retroperitoneal air was identified on the prone cross table lateral view of the rectum. Despite surgical inspection of the colon and pathological examination of the resected specimen, the site of perforation was not discovered. It seems likely that air tracked through the colonic wall into the portal venous system and subsequently dissected through the mesentery or serosa into the peritoneal cavity.

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# Celiac Artery Aneurysms: Case Reports

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**C**ELIAC ARTERY aneurysms are uncommon; however, their propensity towards rupture and exsanguinating hemorrhage encourages alertness to the diagnosis and treatment options prior to a catastrophe. Contemporary diagnostic modalities afford a means to discern celiac artery aneurysms in asymptomatic patients or those with nonspecific complaints. Aneurysm resection with visceral arterial revascularization provides a definitive therapeutic approach in patients suitable for surgery. Two recent patients with celiac artery aneurysms focus attention on many of the diagnostic and surgical aspects involved in the care of such patients.

## Case Reports

*Case 1.* S.F. is a 38-year-old man with a history of intermittent abdominal discomfort who was admitted to Fairfax Hospital in June 1989 for evaluation of severe left upper quadrant abdominal pain. The phys-

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ical examination revealed mild splenomegaly and left upper quadrant tenderness.

A computerized axial tomographic scan demonstrated a large area of splenic infarction and midline vascular mass (Fig. 1). Abdominal arteriography revealed a 3-cm aneurysm of the celiac artery associated with a 90% stenosis of the left gastric artery and proximal occlusion of the hepatic and splenic arteries (Fig. 2). A filling defect in the central portion of the spleen suggested a parenchymal infarction due to

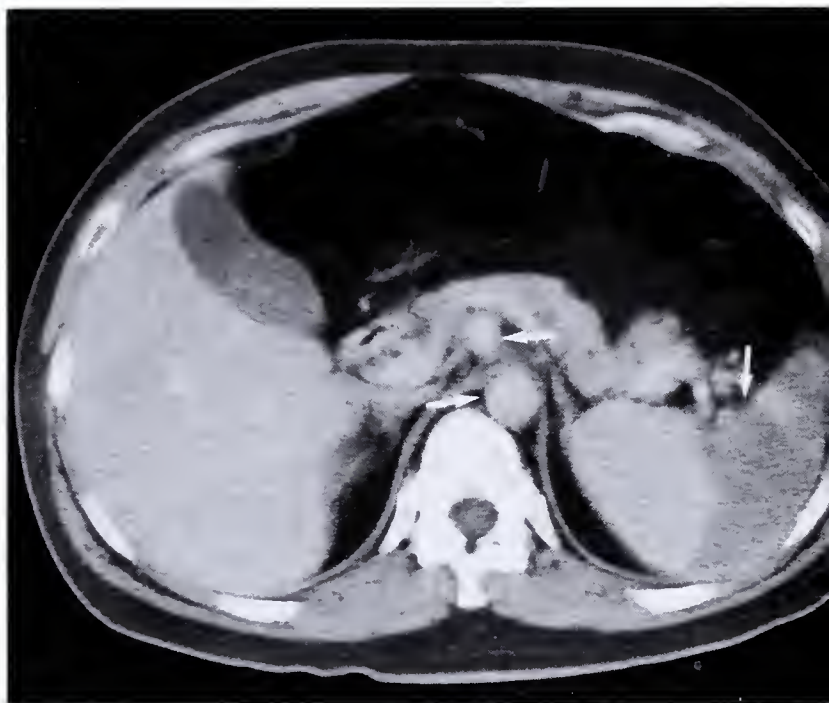


Fig. 1. Computerized axial tomographic scan demonstrating 3-cm celiac artery aneurysm (white arrow, middle) and large splenic infarction (white arrow, right). Abdominal aorta also shown (white arrow, left).



Fig. 2. Abdominal arteriography revealing 3-cm celiac artery aneurysm (white arrow, left) and left gastric artery (white arrow, right).



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## Recollections: Too Much Heart

**I**t takes a while to know heart when you run across it. There's no category for it on resumes or applications for schools or training positions. But once you have worked and played with someone, you know if it's there. If they've got it, it's evident in most that they do.

I first got to know Lloyd Gibson when he joined our department of surgery to begin his surgical residency. He was heading into orthopedic surgery but needed the required basic years of general surgery before specializing. Lloyd wasn't flashy about much of anything. In fact, at first he seemed very average. He was average in height, a bit overweight, not terribly articulate, and there was nothing flashy about the way he dressed or acted. However, he was quietly efficient. In fact it turned out that he was relentless in his care of his patients. We came to know that whenever Lloyd was on a particular service things would just tend to go well. No complaining, no fussing. Just hard work. There had been others before and since who were as tireless and reliable in their work, but few more so. These are people who have heart.

We have a Sunday afternoon hospital basketball game. Generally the level of play is pretty good. Almost all who play have played high school ball and 30-40% have played some college sport. We're pretty serious about our game. For example, we have been known to sew each other up on the sidelines so we won't have to miss any playing time. After about six months of internship, which is usually every other night call in the hospital, Lloyd showed up after a night on call claiming to be ready to play. He wasn't in the basketball player's mold, being a bit short and a bit heavy, and his warm-up shots confirmed that he was not a classically trained ball player, but our tradition is to let all who work at our hospital play in our game, and though he was picked last, we worked him into our game that day. He held his own, though there wouldn't have been much footage on the highlight film if one were being taken.

Weeks and months passed, and Lloyd kept coming to the games. I noticed that gradually Lloyd wasn't being picked last each day. In fact, when it fell to me to choose, I picked him earlier than most. I knew that one way or another Lloyd would be responsible for more than his share of points in almost every game. He'd somehow steal a ball or two, play good defense on more talented players, and get some unexpected rebounds. In fact, it was remarkable enough that we began calling him "Magic Gibson." It seemed diffi-

cult, if you didn't know him, to explain the results. But I knew him, and I understood. He had heart.

Years passed and Lloyd moved through the protracted years of training, finishing when he was about 35 years old, the culmination of almost 30 years of formal education. He accepted a great job offer to work in a beautiful area of North Carolina. I had no doubt he'd be good at anything he took on, and I was sure he'd be happy doing it. I didn't expect to hear much from him since we weren't close friends.

But to my astonishment, Lloyd paged me one weekend morning a year or so later. He was calling long distance from a university hospital intensive care unit. The call seemed routine for a few moments as I waited for him to ask me for advice about a patient. I was chilled when I realized that *he* was the patient. He had a heart problem, he said, and he had called me because I was one of the few heart surgeons he knew personally. They had just removed the ventilation tube from his airway when he called. He had undergone emergency open heart surgery just the night before. His heart had ruptured! I don't recall hearing of such a thing in a person his age before or since. The explanation was mind-boggling. He had been found to have a sarcoma of the heart, an aggressive, relentless cancer growing out of control. The irony of this overwhelmed me then, and it always will. Lloyd, of all people, had too much heart, a heart that had grown out of control.

We talked about drug and radiation therapy, which were known to be ineffective, and we talked about transplantation, which was not really an option. Lloyd fought with his typical quiet determination, but even his best and most focused effort could not withstand the assault of this cancer. His mind was sharp until the end, we were told, though he withdrew as the dying do in the final days.

In the years that have passed since Lloyd's death, I've thought about him often. I hope there will be others like him. I don't know exactly how to discern who they are when I see their records or even when I interview them. But I know heart when I see it in their work or in their sports or in anything else they do. And every time I see it I'll think of Lloyd and his heart.

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splenic artery thrombosis or embolization from the celiac artery aneurysm.

A laparotomy was performed with exposure of the celiac artery aneurysm gained through the lesser omental sac (EAL). A partial occluding clamp on the aorta behind the origin of the celiac axis allowed resection of the aneurysm and suture closure of the aortic orifice. The thrombosed splenic artery was ligated. The hepatic and left gastric arteries were revascularized using a Y-shaped saphenous vein graft originating from the infrarenal abdominal aorta. When the celiac artery aneurysm was incised it was noted to be partially filled with thrombus.

The patient recovered well and is asymptomatic 18 months after surgery. A followup arteriogram documented patency of the saphenous vein Y-graft and absence of other visceral arterial aneurysms (Fig. 3).

**Case 2.** A.T. is a 53-year-old man who underwent evaluation for vague abdominal pain. Ultrasonography revealed a midline arterial aneurysm. Abdominal arteriography documented a 3.5-cm celiac artery aneurysm.

The aneurysm was resected and the aortic orifice closed (QM). A 10-mm Dacron graft was sutured to an elliptical cuff of the arterial wall, which included the unobstructed origin of the hepatic, splenic and left gastric arteries. As in the first patient, the graft was brought through the transverse mesocolon and sutured to the infrarenal abdominal aorta. The patient recovered and has remained well one year after operation.

## Discussion

Celiac artery aneurysms are rare, accounting for 4% of all splanchnic artery aneurysms, and ranking behind the splenic, hepatic, and superior mesenteric arteries as a source of aneurysmal disease.<sup>1</sup> A review by Graham et al in 1985 collated only 108 reported celiac artery aneurysms since the first description in 1830.<sup>2,3</sup> Until recently, celiac artery aneurysms were recognized almost exclusively at autopsy as a result of rupture.<sup>4,7</sup> The first 33 cases collected included 30 patients who died from rupture and exsanguinating hemorrhage.<sup>4</sup> With the increased application of arteriography, computerized axial tomography and two-dimensional, ultrasonography, celiac artery aneurysms may easily be detected prior to rupture. Accordingly, the frequency of rupture at the time of diagnosis has decreased to less than 15%.<sup>2</sup>

The pathologic process most often associated with celiac artery aneurysms is atherosclerosis, although degenerative, infectious, and traumatic etiologies have been observed. Importantly, concomitant aortic and other splanchnic artery aneurysms often coexist.<sup>1,2</sup>

Although occasionally asymptomatic and discovered during evaluation of an unrelated problem, celiac artery aneurysms may be associated with nonspecific epigastric discomfort. The diagnosis of a celiac artery aneurysm occasionally is suggested by midline upper



**Fig. 3.** Followup arteriogram demonstrating patent saphenous vein Y-graft (white arrow, middle) to hepatic (white arrow, left) and left gastric artery (white arrow, right).

abdominal calcification on plain x-ray film or aneurysmal dilatation during ultrasonography, but confirmation usually is dependent on computerized axial tomography.<sup>7,10</sup> Arteriography is helpful to evaluate the possibility of associated arterial disease and delineate the precise pathologic anatomy of the three celiac axis branches. Awareness of the direct and collateral arterial blood flow to the liver may be especially helpful when planning resection of the aneurysm.

Erosion or compression of the intestines, bile ducts, or pancreas by a celiac artery aneurysm may cause abdominal pain or occult hemorrhage.<sup>4,11,12</sup> Our first patient experienced severe left upper quadrant abdominal pain due to embolization or thrombosis of the splenic artery, producing a large infarction of the spleen. The most important complication of celiac artery aneurysms is rupture within the lesser sac leading to exsanguinating hemorrhage into the free peritoneal cavity.

Aneurysm resection is the appropriate treatment in patients with a celiac artery aneurysm in whom the risk of surgery is low.<sup>6</sup> An approach through the abdominal midline in the lesser sac is perfectly adequate without the need for the more debilitating thoracoabdominal incision. Once the aneurysm has been resected, revascularization opportunities may be matched to the patient's pathologic anatomy and needs. Ligation of all three branches of the celiac axis may be accomplished without deficit in a large proportion of patients, especially those with enhanced collaterals through an unobstructed superior mesenteric-to-distal hepatic artery system. However, hepatic ischemic necrosis has occurred on occasion following celiac axis ligation alone.<sup>13,14</sup> Therefore, in patients with a coexisting splanchnic artery stenosis or young patients who may develop a subsequent arterial prob-

lem and in whom the risk of extending the operation is very low, celiac artery revascularization is warranted. The alternatives available include reimplantation of the celiac or hepatic artery to the aorta and interposition of an autogenous saphenous vein or prosthetic graft. The choice of location for the inflow attachment of the graft depends on conditions of the aorta and branch vessels. The celiac and supraceliac portion of the aorta are readily available, although inflammatory states and the patient's configuration may render access somewhat difficult. Our use of the infrarenal abdominal aorta with passage of the graft through the base of the transverse mesocolon simplified performance of the anastomoses and allowed a smooth course for the grafts.

Patients who have undergone successful surgery for a celiac artery aneurysm should be followed periodically for the potential late formation of an abdominal aortic or other visceral arterial aneurysm.

### Summary

Two recent patients with celiac artery aneurysms focus attention on the relevant diagnosis and therapeutic alternatives that lead to a successful outcome in these patients. Awareness of the nonspecific symptoms associated with splanchnic arterial aneurysms combined with ultrasonography, computerized axial tomography, and arteriography lead to the appropriate diagnosis of a celiac artery aneurysm prior to rupture and exsanguinating hemorrhage. Aneurysm resection offers a definitive means of treatment. Selective use of revascularization techniques bolsters the surgical approach by preventing hepatic ischemia and serving as an additional source of visceral arterial blood flow. Our use of an autogenous or prosthetic graft from the intrarenal abdominal aorta proved to be a helpful adjunctive technique. Long-term vigilance is important because of the association of celiac artery aneurysms with other arterial occlusive and aneurysmal disease.

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# ABSTRACTS

*These abstracts are of papers to be presented at the 2nd Annual Virginia Thoracic Society Research Symposium on October 18 in Williamsburg. Dr. Curtis N. Sessler is program chairman. The Society is the medical section of the American Lung Association of Virginia, which funded much of this research.*

**Pulmonary Intravascular Macrophage vs Peripheral Monocyte: Disparity in Endothelial Adherence.** D.E. Bechard, MD, C.J. Walsh, MD, P.G. Mullen, MD, A.A. Fowler, MD, and H.J. Sugerman, MD, Richmond.

The pulmonary intravascular macrophage (PIM), a phagocytic cell adherent to the pulmonary vasculature, is derived from circulating monocyte (MONO) precursors. We examined whether the differentiation of MONO into PIM was associated with alteration in the capacity to adhere to cultured porcine pulmonary artery endothelium (PAEndo). PAEndos were cultured in M-199 medium with 5% fetal bovine serum and 1% Pen/Strep and grown to confluence in flat bottom 96-well plates. MONOs were isolated from arterial blood by Ficoll-Hypaque centrifugation and suspended in Hanks balanced salt solution (HBSS) at  $15 \times 10^6$ /ml. PIMs were harvested from the pulmonary circulation of anesthetized pigs by infusion of 0.025% collagenase as previously described and suspended in HBSS at  $15 \times 10^6$ /ml. Cells were labelled with 300  $\mu$ Ci  $^{51}$ chromate  $\times$  90 min, washed  $\times$  3 in HBSS, and resuspended in M-199 at  $6 \times 10^6$ /ml. 50  $\mu$ l of the cell suspension (PIM or MONO) were added to each well containing 50  $\mu$ l of the appropriate agonist. Plates were incubated for 1 hour (37°C, 5% CO<sub>2</sub>) and fixed in 100  $\mu$ l of 2% glutaraldehyde for 10 min. Wells were vigorously washed in HBSS  $\times$  3, and the remaining adherent cells solubilized with 2% Triton X-100. Released gamma activity was harvested and compared to the total activity placed in the wells at time 0. % Adherence = Recovered CPM/Initial CPM, (mean  $\pm$  SEM, \*p < 0.01 vs baseline;  $\square$  #p < 0.01 vs MONO). Exposure to identical collagenase concentrations had no effect on MONO adherence. We conclude that PIMs demonstrate enhanced capacity to adhere to cultured PAEndos compared to MONO both at baseline and in response to stimuli.

n = 8	Baseline	LPS 1 $\mu$ g/ml	PMA 10 ng/ml
PIM	36.1 $\pm$ .9*	45.2 $\pm$ 1.1**	51.4 $\pm$ 1.7**
MONO	23.1 $\pm$ 1	32.2 $\pm$ 1.6*	36.4 $\pm$ 1.9*

**Risk Factors for Inner City Pediatric Asthma.** Robert S. Call, MD, S.M. Pollart, MD, and T.A.E. Platts-Mills, Charlottesville; T.F. Smith, MD, and E. Morris, MD, Atlanta, Georgia.

The mortality and morbidity of asthma has been increasing over the last 10 years; especially for the black population and among children. A case control study was performed on inner city pediatric patients who presented to Grady Memorial Hospital in Atlanta with wheezing. The patients were studied for IgE antibodies to common inhalant allergens and the levels of allergens in their houses. Patients were randomly selected from a population of wheezing children aged

3-15 years. Serum was obtained and an epidemiological questionnaire filled out. Dust was collected from bedding and/or floors of the patients residences where possible. Dust was assayed using monoclonal antibody based ELISA assays for cat (*Fel d* I), dust mite (Group I), and cockroach (*Bla g* I) allergens. Serum was assayed for total IgE and specific IgE to cat, dust mite and cockroach allergens. Data was available for 41 patients and 23 controls enrolled in 1987 as well as the 40 patients and 40 controls enrolled in 1990. The dominant sensitivities among the asthmatic children were dust mite and cockroach. Allergy to cats was unusual as was cat allergen (or cats) in the houses. Serum IgE antibody to mite or cockroach allergen was found in sera from 56 of 81 asthmatics and 17 of 63 controls (odds ratio 6.1 confidence interval 3.0-12.3). The combination of >100 RAST units and relevant exposure was found in 16/34 asthmatics and 2/23 controls.

The results suggest that approximately two-thirds of ER visits for asthma were related to that risk which is associated with sensitization to one of the indoor allergens.

**Measurements of Salivary Cotinine to Judge Tobacco Smoke Exposure in Wheezing Children Evaluated for Viral Respiratory Tract Infection and Inhalant Allergy.** A.L. Duff, MD, E. Pomerantz, MD, L.E. Gelber, MD, A.H. Farris, MD, F.G. Hayden, MD, T.A.E. Platts-Mills, MD, and P.W. Heymann, MD, Charlottesville.

Multiple factors are known to contribute to wheezing episodes in childhood including genetic predisposition, allergen exposure, viral infections, and environmental influences such as tobacco smoke. Since 30-40% of adults are smokers, children in these households are commonly exposed to tobacco smoke and are reported to be at greater risk for more frequent respiratory tract infections and otitis media. In 61 children treated in the pediatric emergency room at the University of Virginia, tobacco smoke exposure was assessed by questionnaire analysis and measurements of cotinine, a major metabolite of nicotine, in saliva. By RIA analysis, the mean concentration of cotinine in saliva from wheezing patients under the age of 2 was = 19.8 ng/ml (n = 14) in those exposed to tobacco smoke by questionnaire (levels > 10 ng/ml were found in 78%). Compared to previous reports, these cotinine levels are high and, in our study, greater than levels in smoke-exposed wheezing patients over age 2 (mean = 7.1 ng/ml, n = 33, p < .01). Mean cotinine concentrations in subjects not exposed to tobacco smoke under age 2 and over age 2 were 2.9 (n = 7) and 3.0 (n = 18) ng/ml, respectively. In the same group, nasal washes from wheezing patients were obtained for viral culture analysis and RSV antigen detection. In patients < age 2, virus was detected in 11 of 18 (61%) washes (7 RSV, 2 rhinovirus, 1 influenza B, 1 enterovirus) as compared to 14 of 38 washes (37%) in patients > age 2 (2 RSV, 12 rhinovirus). In addition, total IgE levels and specific IgE antibody to mite, cat, ragweed, grass, and cockroach allergens by RAST were measured in sera from these patients. Only 2 of 18 children (11%) < age 2 had allergen-specific IgE ab (both to dust mite) and both patients were 21 months old. By contrast, the proportion of wheezing patients > age 2 with IgE ab to one or more of the allergens tested (i.e. RAST positive) was 60% (26 of 43 patients), which was significantly greater than in children < age 2 (p < 0.001) or control patients without respiratory tract symptoms > age 2 (6 of 41



patients = 15%,  $p < 0.001$ ). Total IgE levels in wheezing children  $< \text{age } 2$  were low (geometric mean = 22.5 IU/ml). In wheezing patients  $> \text{age } 2$ , geometric mean levels of total IgE in RAST positive and RAST negative patients were 310 and 31.4 IU/ml, respectively.

These results indicate that inhalant allergy is strongly associated with acute attacks of wheezing in children older than age 2. In many of these children, viral respiratory tract infection and tobacco smoke exposure were documented as additional risk factors. By contrast, evidence for inhalant allergy was uncommon prior to age 2 in children whose attacks of wheezing were more strongly associated with tobacco smoke exposure, resulting in high concentrations of cotinine in their saliva, as well as viral respiratory tract infection.

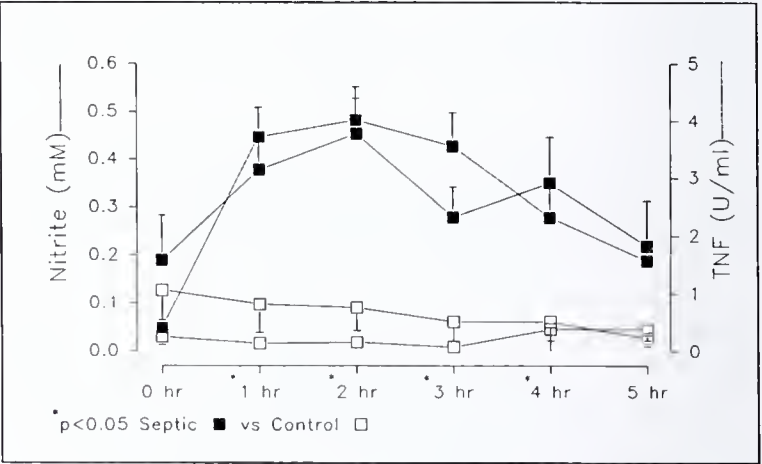
**Immunophenotypic Characterization of Cytokine-Induced Human Multinucleated Giant Cells: Downregulation of CD11b/CD18 (Mac-1) Expression Compared with Macrophages.** R.I. Enelow, MD, G.W. Sullivan, MD, H.T. Carper, MD, and G.L. Mandell, MD, Charlottesville.

The formation of multinucleated giant cells (MGC) is characteristic of the granulomatous response to infection. We have developed a model for the study of MGC using fresh human peripheral blood monocytes cultured in media supplemented with autologous serum, and a combination of recombinant human gamma-interferon and interleukin-3. Using *C. albicans* as a target organism we have found that MGC have substantially greater microbicidal activity and oxidative capacity than identically cultured macrophages, though their phagocytic capacities are not significantly different (Enelow RI, Sullivan GW, Carper HT, Mandell GL: Clin Res 1990;38:480A). We have also examined the effects of extracellular matrix material on MGC formation, and found a modest enhancement of cellular fusion when monocytes were cultured on reconstituted basement membrane ("EHS" tumor matrix). In this study, we examined the expression, on MGC and macrophages, of CD11b/CD18 (Mac-1), a heterodimeric protein of the integrin family of adhesion receptors which appears to mediate adherence of phagocytes to endothelial cells and to extracellular matrix. Using an avidin/biotin peroxidase technique, we found that macrophages cultured in gamma-interferon and interleukin-3 strongly express CD11b/CD18, while MGC express very little. Quantitatively, 77% of macrophages were CD11b/CD18 positive, compared with 5% of MGC. This suggests that CD11b/CD18 may be internalized or shed during macrophage fusion, or that MGC may suppress its expression after formation. Furthermore, CD11b/CD18 may be a mediator of macrophage homotypic adherence, which is an essential step in MGC formation.

**Nitrite and Tumor Factor (TNF) in Sepsis.** J.J. Han, MD, D.E. Bechard, MD, B.J. Fisher, BS, C.J. Walsh, MD, P.G. Mullen, MD, S.K. Woodford, PhD, H.J. Sugerman, MD, and A.A. Fowler, MD, Richmond.

We hypothesized that the rise in TNF seen in sepsis can increase endothelium-derived relaxing factor (EDRF). We infused live *Pseudomonas aeruginosa* ( $3 \times 10^7/20 \text{ kg/min}$ ) for 1 hr into anesthetized, Swan-Ganz monitored Yorkshire pigs ( $n = 8$ ) and measured arterial  $\text{NO}_2^-$  and TNF. Control pigs received saline ( $n = 7$ ).  $\text{NO}_2^-$ , a stable metabolite of EDRF, was measured by a microplate assay based on the

Griess reaction. TNF was measured by the L929 bioassay. Septic swine had elevated  $\text{NO}_2^-$  and TNF ( $p < 0.05$  vs Controls) associated with hypotension. There were no differences in PCW or CO. Infusion of L-arginine (100 mg/kg) into the distal pulmonary artery catheter caused a transient hypotension in controls ( $n = 2$ ) that was reversed with N-nitro-L-arginine (4.5 mg/kg). Associated with L-arginine infusion was a 4X rise in arterial  $\text{NO}_2^-$  levels over 15 min. L-arginine, N-nitro-L-arginine, and *Pseudomonas* mixture had negligible amounts of  $\text{NO}_2^-$ . Our findings suggest that septic shock may be mediated through EDRF release that is coupled with TNF.



**Increased Expression of Gamma-Glutamyl Transpeptidase by Pulmonary Artery Endothelium Following Liposome-Mediated Transfection.** J.K. Jenkins, MD, A.D. Carter, PhD, T. Cheattle, BS, and D.E. Bechard, MD, Richmond.

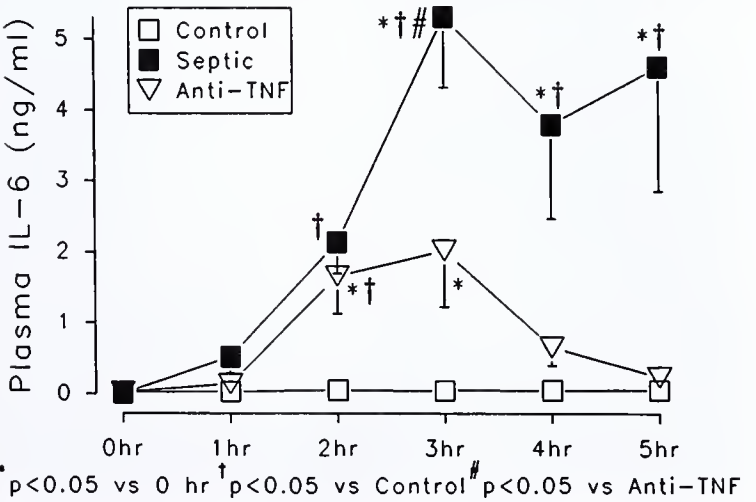
Oxidant-mediated injury of pulmonary vascular endothelium plays a central role in the pathogenesis of pulmonary oxygen toxicity, ARDS, and other pulmonary disorders. Selective enhancement of endogenous endothelial antioxidant defenses via gene transfer techniques may represent a powerful new means of attenuating oxidant-mediated endothelial injury and preserving microvascular integrity in these disorders. The glutathione oxidation-reduction cycle is the primary endothelial antioxidant defense and is dependent upon intracellular levels of reduced glutathione (GSH) and cellular capacity for increased GSH synthesis during oxidant stress. Gamma-glutamyl transpeptidase (GGT) regulates the uptake of substrates for GSH synthesis and is an important determinant of GSH synthesis in response to an oxidant stress. Pulmonary vascular endothelial cells express low levels of GGT activity which may limit their capacity to withstand oxidant stress. We hypothesize that enhanced expression of GGT by pulmonary vascular endothelium mediated via gene transfer will result in increased capacity for GSH synthesis during oxidant stress and attenuation of oxidant-mediated endothelial injury. We report preliminary results demonstrating increased pulmonary artery endothelial cell GGT expression *in-vitro* following liposome-mediated transfection. A full length cDNA of the human GGT gene (courtesy HC Pitot, U of Wisconsin) was cloned into a plasmid vector downstream of the SV40 early promoter and the resulting plasmid (pSV<sub>2</sub>GGT) was amplified in *E. coli* and purified by double cesium chloride density gradient centrifugation. Pulmonary artery endothelial cells (bovine or porcine) were grown to 60-80% confluence in T-25 flasks in M199 media supplemented with 5% FBS and transfected by replacing the culture media with 4 ml of Opti-MEM1 (Gibco/



BRL) containing mixtures (1:5, w:w) of pSV<sub>2</sub>GGT (0.5-5.0  $\mu$ g) and Lipofectin (cationic liposomes, Gibco/BRL, 2.5-25  $\mu$ g). Following incubation (37°C, 5% CO<sub>2</sub>, 6 hr) the Opti-MEM1 was replaced with fresh culture media and the cells were cultured for an additional 36 hrs. The endothelial monolayer was washed twice with PBS, harvested with trypsin/EDTA, pelleted (4°C, 5 min, 400 g), washed with HBSS, pelleted, and resuspended for assay in 500  $\mu$ l HBSS. GGT activity was assayed using L-gamma-glutamyl-3-carboxy-4-nitroanilide as the substrate and glycylglycine as the acceptor as previously described. The concentration of p-nitroaniline produced was determined from OD 410 nm using an extinction coefficient of 9500 M<sup>-1</sup>cm<sup>-1</sup>. GGT activity was expressed as U/mg cell protein where 1 U equals formation of 1 nmol p-nitroaniline/min at 37°C. Control GGT expression was low in both porcine (0.2 U/mg) and bovine (0.6 U/mg) cells. GGT activity in transfected cells was noted to increase in a dose dependent fashion to a maximum of 19 U/mg (31 fold increase) in bovine cells (pSV<sub>2</sub>GGT 4  $\mu$ g/Lipofectin 20  $\mu$ g) and 1.2 U/mg (6 fold increase) in porcine cells (pSV<sub>2</sub>GGT/Lipofectin = 4/20). Histochemical staining of cytospin preparations of porcine endothelial cells using gamma-glutamyl-4-methoxy-2-naphthylamide as the substrate as previously described demonstrated minimal GGT staining in control cells. Cells staining intensely positive for GGT were noted in transfected cells with the relative number increasing in a dose dependent fashion. These results demonstrate that pulmonary artery endothelial expression of GGT can be markedly increased following liposome-mediated transfection with a plasmid vector containing the human GGT gene. Further work is needed to optimize the transfection conditions for the two cell lines and to determine whether increased endothelial GGT expression results insignificant alterations in cellular function and resistance to oxidant stress.

**Passive Immunization Against TNF $\alpha$  Attenuates Plasma Interleukin-6 in Porcine Sepsis.** P.G. Mullen, MD, B.J. Fisher, BS, C.J. Walsh, MD, S.K. Woodford, PhD, G.J. Jesmok, PhD, B.M. Susskind, PhD, A.A. Fowler, MD, and H.J. Sugerman, MD, Richmond

Tumor necrosis factor (TNF $\alpha$ ) is an important mediator of gram negative sepsis. TNF $\alpha$  appears early in sepsis and propagates a complex cytokine cascade. The present study examines the interaction between TNF $\alpha$  and interleukin-6 (IL-6) production in a porcine model of gram negative sepsis. Three groups of animals were studied. Group I (n = 9) received a 60 min infusion of live *Pseudomonas aeruginosa*



(ps,  $5 \times 10^8$  CFU/ml at 0.3 ml/20 kg/min). Group II (n = 4) received monoclonal antibody to TNF $\alpha$  (anti-TNF $\alpha$  MoAb, 15 mg/kg, iv) prior to Ps. Group III (n = 9) received sterile saline only. Plasma TNF (U/ml, L929 bioassay) and IL-6 (ng/ml, 7TD1 bioassay) were measured hourly over a 5 hr study period. Group I had significantly (ANOVA,  $p < 0.05$ ) increased plasma TNF activity while Groups II and III had no detectable TNF activity (data not shown). Anti-TNF $\alpha$  MoAb significantly (ANOVA,  $p < 0.05$ ) attenuated, but did not abolish plasma IL-6 in group II. These data suggest that plasma IL-6 is predominantly, though not solely, TNF $\alpha$  dependent following onset of gram negative sepsis.

**Severity of Theophylline Toxicity Following Chronic Over-medication Reflects Patient Age and Underlying Illness Rather than Serum Theophylline Concentration.** C.N. Sessler, MD, and W.J. Brady, MD, Richmond.

Ingestion of excessive doses of theophylline can result in elevated serum theophylline concentrations (STC) and clinical toxicity. The majority of theophylline toxic patients have ingested multiple excessive doses, i.e. "chronic over-medication," rather than a single dose, i.e. "acute overdose". The severity of toxicity is highly variable, ranging from mild to life-threatening. Several studies have demonstrated a strong correlation between STC and severity of toxicity for patients with acute overdose. In contrast, the relationship between STC and severity of toxicity is inconsistent for patients with chronic overmedication. We examined clinical factors which might influence the severity of toxicity. Additionally, we sought to identify patients at risk for delayed onset of moderate-to-severe toxicity; such patients might benefit from close monitoring and/or prophylactic therapy. Factors examined included age, severity of illness on presentation (using the "rapid acute physiology" score), presence of chronic organ dysfunction, pre-existing theophylline target end-organ disease (heart or CNS), as well as initial STC. Records of 102 consecutive patients who presented to our Emergency Departments with STC  $> 30$  mg/L from overmedication were reviewed. Average age was 50 yrs and the initial STC,  $40 \pm 10$  mg/L. 51 patients (50%) had moderate or severe toxicity (seizures, shock, ventricular or atrial tachyarrhythmias, PVCs, altered mental status, severe acid-base disturbance, or serum K<sup>+</sup>  $< 2.5$  mEq/L). Severity of toxicity correlated positively with age ( $p < 0.05$ ), chronic organ dysfunction ( $p < 0.01$ ), and theophylline end-organ disease ( $p < 0.05$ ) but not with initial STC or severity of illness at presentation. The 13 patients who developed moderate or severe toxic manifestations after the initial ED evaluation more frequently had theophylline target end-organ disease ( $p < 0.05$ ), and a trend toward more chronic organ dysfunction ( $p = 0.07$ ). Age, initial severity of illness, and STC correlated poorly ( $p > 0.1$ ) with the delayed onset of moderate-to-severe toxicity.

We conclude that the severity of toxicity following chronic theophylline overmedication reflects the underlying state of health (chronic organ dysfunction and/or advanced age) to a greater extent than the degree of STC elevation.

**Effect of Nasal CPAP Therapy on Automobile Simulator Performance and Self-Reported Auto Accidents in Patients with Obstructive Sleep Apnea.** P.M. Suratt, MD, and L.J. Findley, MD, Charlottesville.

Patients with obstructive sleep apnea (OSA) have an

increased rate of automobile accidents. They also report difficulty remaining alert while performing boring, repetitive tasks. The purpose of this study was to test the hypotheses that successful treatment of patients with OSA with nasal CPAP would 1. improve performance on a driving simulator and 2. decrease automobile accidents. To test the first hypothesis, we studied 12 patients with OSA before and after 3 to 5 months of treatment with nasal CPAP and 10 control subjects without sleep apnea before and after a 3 to 5 month period. Driving simulator performance was tested with a computer program, "Steer Clear," which for 30 minutes displays an automobile moving on a two lane highway. Seven-hundred-eighty-seven obstacles (steers) intermittently appear in the automobile's lane; to avoid hitting an obstacle, the subject presses the space bar on the computer. All patients improved their apnea after CPAP ( $64 \pm 8$  oxyhemoglobin desaturations/hr. of sleep without CPAP vs.  $2 \pm 1$  desaturations/hr. of sleep with CPAP,  $P < 0.01$ ). After 3-5 months of treatment with nasal CPAP each of the 12 patients with apnea hit a smaller percentage of road obstacles than before treatment ( $3.7\% \pm 0.6\%$  before treatment vs.  $1.4\% \pm 0.3\%$  after treatment,  $p < 0.05$ ). These patients showed a greater improvement on Steer Clear after treatment than the 10 control subjects ( $p < 0.01$ ). There was a significant correlation between the percentage decrease of oxyhemoglobin desaturations per hour of sleep on nasal CPAP and the decreased percentage of obstacles hit on Steer Clear among the 12 patients ( $r = 0.94$ ,  $p < 0.01$ ). In addition, there was a significant correlation between the percentage increase in median oxyhemoglobin saturations during sleep on nasal CPAP and the decreased percentage of obstacles hit on Steer Clear among the 12 patients ( $r = 0.88$ ,  $p < 0.01$ ). To test the hypothesis that treatment with nasal CPAP decreases the number of automobile accidents, we surveyed all patients successfully treated with nasal CPAP in our sleep laboratory in 1988 who were still using CPAP and who had been driving 2 years before and 2 years after using CPAP. Patients were asked the number of "near misses" they had per month and the number of automobile accidents they had in the two years before and the 2 years after using nasal CPAP. After using nasal CPAP there was a significant decrease in the number of patients having monthly "near misses" (13 of 22 before vs 0 of 22 after,  $p < 0.0001$ ) and having automobile accidents (9 patients had 13 accidents before vs 1 subject had 1 accident after,  $p < 0.005$ ).

We conclude that in patients with OSA treatment with nasal CPAP improves their driving simulator performance and reduces their frequency of automobile accidents.

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*The following abstracts derive from the annual meeting of the Virginia Dermatological Society on November 4, 1990, in Hot Springs. Dr. Robert J. Pariser was program chairman.*

**Linear IgA Bullous Dermatitis.** John D. Hendrix, MD, Charlottesville.

A 65-year-old white female presented with a generalized vesico-bullous eruption of 4-weeks duration. A previous history included a blistering eruption diagnosed as cicatricial pemphigoid. Physical examination showed annular lesions with a peripheral urticated ring of blistering and erosions distributed over the trunk and lower extremities. In addition there were erosions of the mucosa of the oropharynx with evidence of scarring and some inflammation and symblepharon of the conjunctiva. A skin biopsy revealed subepidermal vesiculation with a superficial neutrophilic infiltrate. Direct immunofluorescence showed linear deposition of IgA at the basement membrane zone. There was no deposition of IgG, IgM or C3. Indirect immunofluorescence was negative. Treatment given was dapsone and low-dose prednisone.

Linear IgA bullous dermatitis is the currently accepted term for a rare autoimmune blistering eruption of the skin and mucosa in which IgA is found to be deposited in a linear fashion at the dermoepidermal junction. The disease clinically can resemble bullous pemphigoid or dermatitis herpetiformis in adults. It also occurs in a childhood form as so-called "chronic bullous dermatosis of childhood." The lesions appear as tense vesicles and bullae on a more or less inflammatory base. Annular rosette-like formations of blisters are said to be relatively common. Mucosal surfaces can be involved. The disease generally runs a chronic and intermittent course. In the childhood form, remission after months or years of activity is common. Diagnosis is established by the histopathologic demonstration of a subepidermal vesicular eruption and by immunofluorescence demonstration of IgA at the dermoepidermal junction. The most commonly used therapeutic agents are corticosteroids and dapsone, either alone or in combination, which generally can be expected to produce suppression of the disease.

**Fungal Infections in Immunocompromised Hosts.** Peter W. Jaber, MD, Charlottesville.

Case 1. A 72-year-old man with hairy-cell leukemia was hospitalized for pancytopenia and fever. He was found to have several expanding necrotic macular lesions on both lower legs. Among his laboratory studies was a white count of 7.1 with 99% blasts. Cultures were positive for *Staphylococcus aureus* and *Pseudomonas aeruginosa*. A skin biopsy showed extensive necrosis with ulceration. There was a massive overgrowth of fungal organisms. A fungal culture subsequently identified these as a *Fusarium* species. The diagnosis was, therefore, cutaneous fusariosis. Despite high dose amphotericin B therapy and broad-spectrum antibiotics, the patient expired 10 days later from overwhelming polymicrobial sepsis.

Case 2. An 8-year-old girl with acute lymphocytic leukemia was hospitalized because of pancytopenia and "right chin cellulitis." Examination revealed a 2 x 2 cm hemorrhagic, violaceous macular lesion with surrounding erythema on the right side of the chin. She had a white count of 100. Blood cultures and superficial skin cultures were negative. A skin biopsy showed coagulative necrosis with exten-



sive fungal overgrowth. A fungal culture later identified the organism as *Aspergillus flavus*, thus establishing the diagnosis of primary cutaneous aspergillosis. Treatment consisted of amphotericin B and antibiotics but the patient subsequently expired from progressive leukemia.

The possibility of unusual mycoses should be kept in mind in any immunocompromised patient who presents with progressive skin lesions and fever. The clinical signs and symptoms may be atypical or non-specific and skin biopsy and culture are essential for definitive diagnosis.

**Bromoderma.** Barbara T. Sitton, MD, Charlottesville.

A 55-year-old white woman injured her left hand on a laundry machine. Two weeks later, red lesions developed on both hands, the left great toe and the left forearm. A number of therapeutic and diagnostic measures were undertaken, including oral and intravenous antibiotics, multiple cultures and a skin biopsy; however, the lesions continued to wax and wane without resolution and without definitive diagnosis. Intralesional corticosteroid injections were given which appeared to produce a response, although it was of a transient nature. Physical examination showed multiple erythematous indurated plaques with central turbid vesicles or pustules scattered over the dorsum of the hands bilaterally. There was also a lesion on the forearm and a small erythematous papule on one toe. A skin biopsy showed extensive neutrophilic infiltration with pseudoepitheliomatous hyperplasia. These findings were felt to be consistent with bromoderma. Additional history revealed that the patient was taking an over-the-counter cough preparation which contained bromodiphenhydramine hydrochloride.

Bromoderma (or more generally halogenoderma due to bromine, iodine, or fluorine) is a rare hypersensitivity reaction which presents difficult diagnostic challenges. The lesions typically consist of plaques, nodules and vegetations which may become hyperkeratotic or pustular. The diagnosis becomes easier once the lesions are suspected clinically. Skin biopsy findings are confirmatory, although deep tissue mycoses can produce a similar pattern. Treatment consists of identifying and avoiding the agent responsible. Most of these are over-the-counter medications, the administration of which may not emerge in routine history taking unless specifically asked for.

**Fatal Primary Cutaneous T-Cell Lymphoma.** Robert M. White, MD, Roanoke.

A 65-year-old white woman was initially seen in September 1985 with the gradual onset of painless, nonulcerated, erythematous cutaneous nodules which primarily involved the right arm and hand. The lesions slowly enlarged over the next several years. A skin biopsy showed a polymorphous lymphoid infiltrate in which there were eosinophils, plasma cells and large transformed lymphocytes. Immunoperoxidase studies showed a clonal helper T cell population with a non-mycosis fungoides/Sézary syndrome phenotype. Southern blot analysis demonstrated clonal rearrangement of the T cell beta and gamma receptor genes, indicating a clonal T cell neoplasm. A bone marrow examination and CT scan were unremarkable. After new lesions developed on her right flank, shoulder and hands, she received multiagent chemotherapy consisting of cyclophosphamide, USP (Cytosan®), doxorubicin hydrochloride, USP (Adriamycin™), vincristine sulfate injection (Oncovin®) and prednisone. This resulted in initial clearing of her lesions; however, following

therapy, the lesions soon recurred. They were then treated with electron beam radiation and again regressed. Additional recurrences in February 1989 responded to courses of chemotherapy. Repeat biopsies at this time again showed the presence of large atypical lymphocytes with the T helper cell phenotype. The patient was readmitted to the hospital in September of 1989 with massive cutaneous infiltration of her entire right forearm and hand. A palliative above-the-elbow amputation was performed. Tumor in this specimen showed compact, anaplastic, large immunoblastic cells with soft tissue infiltration. Attempts at additional radiation therapy were given but the patient developed progressive anorexia, vegetative behavior, and deteriorating liver status, followed by death, 48 months after onset of disease. No autopsy was obtained.

The clinical and pathologic spectrum of T cell neoplasia is diverse and frequently perplexing. In addition, in recent years it has become apparent that the skin may serve as a lymphoid organ, attracting and promoting proliferation of T-lymphocytes. This case illustrates the potentially aggressive, sometimes mutilating, and even fatal course of T cell cutaneous neoplasia. While T cell neoplasms are clinically and pathologically heterogeneous, they share in common monoclonal T cell proliferation. Monoclonality and lineage can be reliably established by current, standard laboratory methods including immunoperoxidase staining of frozen tissue as well as by molecular genetic (DNA) analysis. These readily available techniques can enhance our understanding of the biology of these neoplasms and possibly provide a basis for improved therapy.

**L-Tryptophan Induced Bullous Morphea.** Robert B. Scoggins, MD, James W. Patterson, MD, and Duncan S. Owen, MD, Richmond.

The case of the 62-year-old white woman presented at the 1989 meeting of the Virginia Dermatological Society is reevaluated in light of new findings related to cutaneous manifestations of L-tryptophan ingestion. The patient had gradual onset of lower leg tenderness in 1988 followed by swelling and development of progressive, edematous, firm, well-delineated, cutaneous induration of the extremities. Blisters were seen on her right shin in February of 1989 which subsequently involved both shins and forearms. She has had no signs of systemic or internal organ disease. Examination in March of 1989 showed tensely firm skin from the dorsae of the feet to the buttocks with sparing of the medial thighs. Her forearms and much of her upper arms were similarly involved. A well demarcated white plaque was present on the abdomen. There were vesicles on the right shin. Some of these later became confluent and bullous. Some hemorrhage into the blisters was also noted. Laboratory studies included a normal CPK, eosinophil count, urinalysis, and routine blood chemistries. Thyroid studies were normal, anti-scl-70 antibodies and rheumatoid factor were negative. ANA was 1:160 on one occasion but two subsequent determinations were negative. A skin biopsy showed the epidermis to be somewhat acanthotic. There was marked sclerosis of the dermis, the septae of the subcutaneous tissue and the superficial fascia. Focal inflammatory infiltrates consisting mostly of lymphocytes and plasma cells were present around vessels in the upper dermis, at the dermal-subcutaneous junction, and in the deep subcutis, and diffusely in the fascia with extension into the skeletal muscle. Atrophy of dermal appendages was noted. No eosino-



phils were present. Diagnosis was felt to be generalized morphea with bullae. Treatment was low dose oral prednisone which produced little response. Additional history revealed that the patient had been ingesting 2,000 mg a day of L-tryptophan from May 1987 through October 1988. Occasional elevation of eosinophil count was noted up to a level of 13%.

The expanding syndrome of the eosinophilia myalgia syndrome associated with the ingestion of L-tryptophan includes scleroderma-like findings in the skin as well as a number of systemic dermatologic problems. It seems likely that this patient falls into this spectrum. There is evidence that a contaminant in the commercially available tryptophan preparations is the agent responsible for the syndrome.

#### **Necrobiotic Xanthogranuloma in "Inverse" Distribution.** James W. Patterson, MD and Yvonne Knight, MD, Richmond.

A 58-year-old woman presented with nodular lesions of 10-15 years duration, on both arms. The lesions had the clinical appearance of keloids or sarcoidal granulomas. On physical examination, there appeared to be surface changes reminiscent of lupus erythematosus. No lesions were noted on the trunk but somewhat yellowish plaques were observed in both periorbital areas. Her general health was good; specifically, there was no history indicative of diabetes mellitus, hyperlipidemia, or multiple myeloma or related disorders. A skin biopsy revealed a granulomatous dermal infiltrate with extensive necrobiosis. The granulomas contained foamy macrophages and Touton-type giant cells. "Cholesterol clefts" were also identified. Laboratory studies included a negative ANA and serologic test for syphilis. Urinalysis was normal. Cholesterol was 123, triglycerides were 61 mg/dl. Lipid profile was normal. A serum protein electrophoresis revealed low albumin and elevated total globulin and alpha-2 globulin fractions.

Necrobiotic xanthogranuloma with paraproteinemia is a rare condition in which multiple large xanthomatous indurated plaques occur on the skin, particularly in the periorbital and flexural areas. Affected patients show a monoclonal IgG paraproteinemia and in many cases underlying lymphoproliferative disease or myeloma. Hyperlipidemia is a variable feature but is not essential for the development of the lesions. Histopathologic findings are reasonably specific for this entity. Treatment tends to center around the underlying lymphoproliferative process, although in general the prognosis is poor.

#### **Epidermodysplasia Verruciformis With Ocular Involvement.** Robert J. Pariser, MD, Norfolk.

A 49-year-old black man was seen because of a growing 2-cm lesion of the forehead of 9 months duration. Examination showed an irregularly hyperpigmented tumor with central ulceration and crusting. The lesion was removed and a

histopathologic examination showed it to be a squamous cell carcinoma. He was noted to have striking hypopigmented, discrete, barely elevated, patches symmetrically distributed on his chest and back with some extension to the arms and legs. They measured from 4-10 mm in diameter. They showed sharp margination and a somewhat polygonal shape. According to the patient's history they had been present since childhood. The patient's ophthalmologic problems began in September of 1982 with the result of a growing lesion of his left conjunctiva. The lesion was biopsied and was found to be a squamous cell carcinoma in situ. It was excised but eventually recurred. He subsequently had multiple excisions which were followed by multiple recurrences for this in situ carcinoma. At one point he had received x-ray therapy to the eye in an attempt to prevent recurrences. He was receiving ongoing close ophthalmologic follow-up because of this lesion; however, despite this, the viability of the globe is felt to be precarious. This situation is complicated by the fact that he had lost his right eye in an accident several years previously. Histopathologic examination of the hypopigmented macules on his torso showed hyperkeratosis, parakeratosis, acanthosis with some loss of normal epidermal papillations. The granular layer was thickened and the keratohyaline granules were variable in size. Keratinocytes were large with swollen, vacuolated, somewhat basophilic cytoplasm. The normal architecture of stratification was disrupted. The basal and suprabasal layers were relatively intact. The dermis was normal. These findings were felt to be diagnostic of epidermodysplasia verruciformis. Dot blot hybridization studies on lesional and normal skin revealed the presence of HPV 5 and HPV 8 (the HPV 5 signal being much stronger). Non-lesional skin gave a weak signal for HPV 8 only. Electron microscopy failed to reveal any intact virions.

Epidermodysplasia verruciformis is a rare hereditary syndrome in which the affected individuals develop multiple "pityriasis-like" lesions or which resemble flat warts. These are due to infection of the epidermis with a variety of human papillomaviruses; in fact, many of the HPV subtypes described occur only in those affected with this condition. Squamous cell carcinomas can arise from these warty lesions, particularly in areas where there is sun exposure. The forehead is said to be a particularly common site. Ocular involvement is unusual in a number of aspects in this patient in that epidermodysplasia verruciformis has not been previously reported to involve the eye. It is now well accepted that human papillomavirus may be associated with premalignant and malignant lesions of the conjunctiva in normal individuals. No specific treatment for epidermodysplasia verruciformis exists, although transient responses to interferon and systemic retinoids have been recorded. Follow-up consists primarily of surveillance for and treatment of associated squamous cell carcinomas.



# VIRGINIA MEDICAL

## The Doctors' Plan

**T**IME WAS when Blue Cross/Blue Shield was the doctors' health insurance company/plan. That day has long since passed.

When Blue Cross of Virginia was established in 1935 and Blue Shield of Virginia some years thereafter, the two boards of directors included community leaders but were comprised mainly of hospital administrators and physicians; one of these physicians was nominated by the Medical Society of Virginia. Thus policy for the insurance company was dictated primarily by physicians.

Today, not only is Blue Cross/Blue Shield of Virginia not controlled by physicians, but there is little

input from practicing physicians. Policy and management are controlled by the insurance company (read big business) and it deals with big business. As an example, Blue Cross/Blue Shield is contracting with the three for-profit Richmond hospitals in Richmond and has excluded St. Mary's Hospital, a non-profit institution, from the Blue Cross/Blue Shield preferred provider plan. This constitutes yet another instance of big insurance and big business controlling health care. The cost of medical care is not lessened nor is access to health care improved. But there is profit for HCA investors.

E.L.K., JR.

## A Hard Day's Work

**M**Y FRIEND Harold is a big man: a tough, old mountain farmer who, although 75 years old and 20 years my senior, can easily outwork me. But his physical strength is decreasing (as his aches and pains and arthritis are increasing), and he gets a little blue and worried about himself, especially on rainy days when he cannot get out in the fields on his tractor. When the weather is pretty and he can be out in the fields, his attitude about himself quickly improves.

On a beautiful June day after we had finished building a long fence, we were sitting in some shade and admiring our just-completed work. We agreed that

it was a good fence and would do the job for many years.

"You know, Henry," he said, "we worked hard on that fence, and it's a good one. But I sure am tired."

He sipped on his cold drink and continued, "You know, I can do just as good a hard day's work as I ever could even though I am now 75, have a bad leg, and arthritis."

He paused, then added, "Of course, that hard day's work now takes me three to four days."

H.S. CAMPBELL, MD

## Pickup Trucks

**Y**OU WILL recognize the pediatrician and the parent in this lament over the demise, in the last session of the Virginia legislature, of Senate Bill 845, dealing with prevention of the risk to children riding in the

beds of pickup and other single-unit trucks. Senator Stallings was patron of the bill.

According to data collected by the Fatal Accident Reporting System of the National Highway Traffic

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James L. Moore, Jr., *Executive Vice President*

Safety Administration, and quoted in the American Academy of Pediatrics News,<sup>1</sup> 127 children and youth, aged 19 or less, were killed in 1987 while riding in the back of pickup trucks. It is estimated that approximately 1,000 more are injured each year.<sup>2</sup>

How easy it would be to prevent these unnecessary injuries and loss of life by restricting the transportation of passengers in open truck beds. Children are more susceptible to injury; at the very least, the transportation of children should be restricted. E.L.K., Jr.

1. AAP News 1991;7:22
2. National Traffic Highway Safety Administration, USDOT Fatal Accident Reporting System, Washington DC, 1987

## Routine HIV Serology

IF EVER a serious problem has been ineptly managed, AIDS and HIV infection must qualify. The approach to eradication/control has taken some crazy and unlikely turns. The most illogical approach must be that advocated by Senator Jesse Helms. He has introduced legislation requiring that any physician or dentist who performs an invasive surgical procedure be HIV negative under pain of fine and obligatory prison term.

The motive is good, but the approach is wrong. With the number of HIV infected individuals in the United States estimated at more than one million and growing daily, medical personnel, particularly those involved in invasive surgical procedures, are in this context those primarily at risk.

In earlier days, serology for syphilis (Wasserman test, at that time) was required for every hospitalized patient. It was automatic.

Other legislation sponsored by Senator Helms allows for patient testing, but is neither routine nor automatic. HIV serology for every hospital admission would be a move in the right direction. E.L.K., Jr.





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# FROM THE ROSTRUM

## An Ordinary Life

*This is the edited text of the commencement address to the University of Virginia School of Medicine's Class of 1991 on May 19 in Charlottesville.*

DEAN CAREY, Professor Skelton, members of the Class of 1991, parents, families and friends.

Is it not fair to say that the sun never shone so brightly on your collective lives as it does today? Let me tell you, publicly, how great you are. From sharp little kids in grammar school you progressed to bright, attractive teen-agers. At high school graduation many of you were elected "Most Likely to Succeed" and succeed you did. During all that grind of "pre-med nerdism" you hit the books, you survived organic chemistry. You kept your eyes on the prize. And it paid off.

You entered this medical school in September 1987, the brightest class in UVa history, handpicked from a pool of 2429 applicants, with a mean grade point average of 3.53. You continued to work hard and to perform well. In selecting the most competitive and prestigious internships, your composite excellence has once more paid off—62% of you matched with your first choice, 15% with your second. You have done well, good and faithful students, and all of us here today applaud your achievements.

With this great start, and all that momentum, where do you go from here? Surely the sky is the limit.

Some of you will become dedicated researchers, superb grant swingers, who will ceaselessly push ahead on the cutting edge of science, achieving national prominence, the National Academy of Sciences, the Institute of Medicine, awards, honorary degrees, and (who knows?) maybe even the Nobel Prize. But most of you will not.

Some of you, along with research, will remain in the groves of academe, seeking the bubble tenure, then considering chairmanships, even deanships, even vice-presidencies, or more. But most of you will not.

Some of you will mount the ladders of public service with the military, the Veterans Administration, the Public Health Service, etc., or perhaps with private industry or administration. But most of you will not.

Most of you will, one of these days, end up in the private practice of medicine—which is what you said

you wanted four years ago. Is all that too far ahead for us to even begin to think about, or talk about, on this day of days?

In the last General Assembly, House Joint Resolution 391 was passed requiring the state's three medical schools to do a better job of directing our graduates into rural areas. Meetings will be held, input will be sought, papers will be shuffled, and votes will be tabulated. What will be the outcome? Surely, on a fine day like today, we need not get into that.

But let's indulge for a moment in some personal daydreams of a summer's day. Let's just suppose that for any number of reasons, some personal, some professional, perhaps a shared dream of yourself and your spouse, you have elected to go into primary care—and not only that, but to go back to your roots, to hang out your shingle in a peaceful (make that *extremely* peaceful) underserved community in Virginia. What would that be like?

Well, among other things, you would very probably come face to face with the greatest challenge any gifted individual can ever face: what Thomas Wolfe (not Tom Wolfe) described as "the green-gold emptiness of 3 o'clock in the afternoon," what Walker Percy, the late great Southern physician, philosopher and writer, has defined as the quintessential American dilemma: how to live a perfectly ordinary life.

You've never had to do that before. Because you have been extraordinary from Day One, you may not really know how ordinary people (much less people like you) live an ordinary life. Where to find the answer? Who're you gonna call?

You can't review your notes from four years of medical school. You can't call on this outstanding faculty that has tutored and mentored you—they're the last people you'd ask. What do we know about the ordinary life?

But the situation isn't hopeless. There are experts, and they've been there before you. All you have to do is listen. Listen to your patients. They will tell you what to do, by describing the models you should follow. No problem.

For instance, if you should head down Route 20 South, pretty soon you come to Scottsville on the James, arguably the oldest settlement in Albemarle

County. Suppose you opened your office there, and practiced primary care. Whom would your patients want you to be like? Not like John C. Marshall or Rayford Scott Jones—they never heard of them. But they could tell you story after story about Dr. Bill Moody, who retired recently after over 40 years of service to the people on both banks of the James.

They asked Dr. Bill what, in his opinion, was the greatest medical advance made during his professional career. Without a moment's hesitation, he replied, "the Rescue Squad." That tells you something.

Or suppose you headed east, to Palmyra, the county seat of Fluvanna. Nobody there knows Dean Carey, but they'd still get choked up telling you about good old Dr. A. C. Whitley, who wore himself into the grave, taking care of his people.

Or if you ventured down U. S. 29 South, and settled in Lovingsston, they probably never heard of Don Detmer, but the stories they could tell you of the late great Dr. Harry Gamble, who was for so many years Mr. Everything in Nelson County!

You may not, at first, be attracted to models like these. But let me tell you: when the *Alumni News* hits your mailbox with stories of all the honors that your former classmates are winning, and you're sitting there, listening to the grass grow, with 2½ irritable children (and a spouse with a headache, if not a little bit of an attitude problem, too), believe me you will need something, to cope with the greatest fear you've ever known.

That fear, the occupational hazard of extraordinary people, is the fear that you didn't make a difference, that all the bright shining talent has somehow been wasted, that you are stranded now, and forever tied down in this lousy backwater, and the world is passing by. In the words of Marlon Brando, "And you coulda been somebody. You coulda been a contender."

Could it be that you are feeling sorry for yourself?

That, my friends, is when you need Moody, Whitley and Gamble not Marshall, Carey and Detmer. How did these ordinary doctors do it all, and transcend the ordinariness of everyday life to the point where the whole darned county knows that they made a difference. Not only that, but they have become bona fide heroes, loved, revered, remembered always. They made a difference, as all good doctors do, because, to varying degrees, they did three things well.

1. Good doctors make people feel good. How trite, and yet how profoundly true. A smile, a tease, a joke, a laugh—these are the most powerful drugs you can dispense. When you do that—you make a difference. I called Red Skelton "Professor" in all seriousness because what he taught you is one of the most important lessons in medicine.

A minister recently told the story of a visit to one of his parishioners, a woman slowly dying of cancer. They had a good visit, and as he rose to leave, he asked, "Shall we have a prayer before I go?" She

thought for a moment and said, "No, I guess not. We've had a good laugh and sometimes that's as good as a prayer."

I say Amen to that. Thank you, Professor, for your wisdom.

2. Good doctors become better doctors when blessed with a rich family life. To give sick, unhappy people smiles and hope day after day, particularly when you're feeling stressed-out yourself, is hard work. A wise physician has said, "Medicine is less demanding intellectually than we like to believe and far more demanding emotionally than we are willing to admit." How do we meet these demands?

Like ordinary people, we call on our families to recharge our batteries. We run to them as to a cash machine, pounding their buttons, holding out our hands for comfort. But spouse and children need recharging too. Once you've got everything organized, don't just pat yourself on the back and work harder, but take the occasion to cancel all your business and go on a picnic. A physician's son once told his counsellor: "I wish my Daddy loved me half as much as he loves his beeper." Don't let those words be said about you.

3. And finally, good doctors build themselves into their community by obeying the twin commandments: join and serve. It must seem strange to think that private practice equates to an obligation for public service. But that's the way it is. How can you ever expect to make a difference in your community if you don't take part in that community?

When you settle down in your Bedford Falls, join a church, serve on the school board, the town council. Join your local medical society, the Medical Society of Virginia, and the AMA. Serve the rescue squad, the Red Cross, the Boy or Girl Scouts. Join the Rotary, the Kiwanis, the Lions. Serve on the charity committees, on the Community Chest, the United Givers Fund. Join and serve, join and serve. . .

Well, class of 1991, looks like time has gotten away from me again. As usual, I've rambled on and on, the hour is up, and I haven't left any time for questions. And I could have said it all, could have given you the whole secret of leading an ordinary life and still making a difference, in one familiar quotation:

"He who would be greatest among you, let him be the servant of all."

You might want to get out your notebooks and jot that down. I have a feeling it might be on the final exam.

JOHN A. OWEN, JR., MD

Dr. Owen was himself graduated from the University of Virginia School of Medicine in 1948 and is now professor of medicine at his alma mater. Address correspondence to him at Box 242, University of Virginia Health Sciences Center, Charlottesville VA 22908.

Dr. Owen dedicated his address to the memory of "my dear friend," the late Leon I. Block, MD.



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# VIRGINIA MEDICAL OBITUARY

• **Virgil Jefferson Cox, MD**, Galax; Medical College of Virginia, 1934; age 86; died August 2, 1991. A founder of Galax General Hospital (now Twin County Community Hospital), he served as a delegate to Virginia's General Assembly in 1962-65.

• **Lewis Daniel Crooks, Jr., MD**, Richmond; obstetrician/gynecologist; Medical College of Virginia, 1970; age 49; died August 29, 1991.

• **Frances R. Feldman, MD**, Williamsburg psychiatrist; New Jersey College of Medicine, 1964; age 57; died May 10, 1991. Her husband, Stephen E. Slatkin, MD, survives her.

• **Herbert C. Hoover, MD**, retired Petersburg anesthesiologist; Medical College of Virginia, 1949; age 67; died April 29, 1991.

• **Alvin Quarles Jarrett, MD**, Virginia Beach anesthesiologist; Medical College of Virginia, 1953; age 64; died March 1991. A brother, Harry W. Jarrett, MD, Lynchburg, survives him.

• **John P. Jones, MD**, retired Richmond pediatrician; Medical College of Virginia, 1937; age 78; died August 3, 1991.

• **William Roberts Sandusky, MD**, Charlottesville general surgeon; Vanderbilt University School of Medicine, 1932; age 84; died March 20, 1991.

• **James M. Winkfield, MD**, Strasburg general practitioner; Medical College of Virginia, 1932; age 81; died May 24, 1988.

## Memoir of Clyde O'Brien 1910-1990

*By John A. Mathews, MD*

Dr. Clyde Garvis O'Brien, a beloved and devoted physician of Appomattox County for 56 years, died at his residence on Monday, September 21, 1990.

He was born in Lynchburg, Virginia, to the late James Howard O'Brien, Sr. and Nettie Conner O'Brien, and he attended secondary schools in Appomattox County. A graduate of the University of Richmond, he received his MD from the Medical College of Virginia in May 1934 and interned at Gal-

linger Hospital, Washington, DC.

He gave of himself unselfishly to his profession, serving his native Appomattox and surrounding area from 1934 until he died, interrupted only by World War II, when he served as medical officer aboard ship in the U.S. Navy.

He was a faithful member of the Medical Society of Virginia and the American Medical Association and was also devoted to his community, having served as an active member of Liberty Baptist Church, a member of the Board of Appomattox Unit, American Heart Association, the Lions Club, and the Masonic Lodge. He also made numerous contributions to the youth of Appomattox County.

He is survived by his wife, the former Ellen Schweizer of Wheeling, West Virginia, and two daughters, Kitty and Susan.

## Memoir of C.W. Coppedge 1928-1991

*By Ray A. Moore, Jr., MD*

Charles William Coppedge, 62, died unexpectedly in Farmville, Virginia, on May 20, 1991. Born and raised in Powhatan County, he graduated with a bachelors degree from the University of Richmond in 1949 and received his MD from the Medical College of Virginia in 1959. He served his internship and residency and received additional training in ENT surgery at the Charleston Memorial Hospital in Charleston, West Virginia, where he met and married Angie Arrington in 1962. His military service was active duty with the Navy during the Korean War.

Dr. Coppedge was engaged in the practice of general medicine/family practice in Farmville from 1962 until his death. During this period he performed ENT surgery and obstetrics, qualified as one of the three attendings in the coronary intensive care unit at Southside Community Hospital when it was established and had served as chairman of the medical staff. With an intense interest in medical politics and its effects on patients, Dr. Coppedge participated actively in meetings of the Medical Society of Virginia and served on its Committee on Hospital Practice. He was active in community affairs and served as president of the Lions Club and as Secretary to the board of Holly Manor Nursing Home. A faithful church man and Sunday School teacher, he was elected an elder in the Farmville Presbyterian Church. An avid sportsman, he



enjoyed hunting, tennis, snow skiing, and sailboating.

He is survived by his wife; two daughters, Elisabeth Corrigan, South Bend, Indiana, and Emily Gurley, Mechanicsville; three grandchildren, Jonathan, Christopher, and Joseph Gurley; his mother, Mrs. Charles Granville Coppedge, Farmville; a sister, Ann Byrd Anderson, Whitestone; and a brother, Edward Granville Coppedge, Nottoway.

The varying elements of his life blended quietly in Bill Coppedge so that all who knew him saw his devotion to his mother, whom he accompanied on errands with dependable regularity; his loyalty to family as he participated with wife and daughters in the events of their lives; and a deep caring for his patients, whom he was attending with great diligence in the wee hours of the morning of his death. Among his colleagues he was unassuming but staunch in his convictions and known as one who did not refuse the request of another doctor, all the while despairing of how an impersonal government was interjecting itself into the practice of modern medicine.

Dr. Coppedge served his profession and community in exemplary fashion. His highly commendable life and work will long be remembered by his colleagues.

## Memoir of Russell Bowers 1915-1990

*By C. L. Coleman, MD, E. R. Trice, MD, and  
Edwin S. Wysor, MD*

Dr. Russell V. Bowers, a retired family physician, died on October 5, 1990, at his summer home in Deltaville, Virginia. He was 75.

Dr. Bowers was born in Canon, Georgia. His father was a railroad man, and the family lived in Virginia, first at Crewe and Newport News, then at Lynchburg, where Dr. Bowers received his early education. He earned his BS from Lynchburg College in 1937 and an MS in biochemistry at the Medical College of Virginia in 1939. He served as a research assistant in the Department of Biochemistry at the University of Virginia School of Medicine in 1940.

During World War II Dr. Bowers served in the army specializing in chemical warfare at Edgewood Arsenal, where he attained the rank of captain. After the war he entered the Medical College of Virginia and earned his MD in 1950. He was elected to Alpha Omega Alpha. He did his internship at the Medical College of Virginia and Stuart Circle Hospitals. He did general practice in the Mechanicsville area for 37 years prior to his retirement in 1988.

An active and loyal Democrat, Dr. Bowers served as a delegate to the 1960 Democratic National Convention and cast a vote for John F. Kennedy as a presidential elector in 1964. He was a member of the

State Selective Service Board.

Dr. Bowers had a lifelong interest in the Civil War. He was vice chairman of the Henrico Civil War Centennial Committee. Along with the late Ambler Johnson, he was instrumental in establishing the Chickahominy Bluffs Battlefield Park, across the road from his home on Mechanicsville Pike. He wrote several articles on Civil War medicine and contributed Civil War artifacts to both Lynchburg College and the Richmond Academy of Medicine. He was an avid outdoorsman who enjoyed hunting and fishing.

Dr. Bowers is survived by his wife, Jeanne Mathews Bowers, Richmond; five children, Daniel R. Bowers, Mechanicsville; John M. Bowers, Las Vegas, Nevada; Robert D. Bowers, Chester; Pamela Bowers Watson, Richmond; and Martha Bowers Tapia, Garden Grove, California; and eight grandchildren.

## Memoir of Jack W. Hall 1932-1990

*By Clifford G. Gaddy, MD, and  
Lawrence G. Fehrenbaker, MD*

Jack W. Hall, MD, of Danville, Virginia, died on October 23, 1990, after a brief illness. He was born on December 11, 1932, in Birmingham, Alabama.

Dr. Hall moved to Sandston, Virginia, early in his youth and graduated Phi Beta Kappa from the University of Richmond in 1955. He attended the Medical College of Virginia where he was a member of the Alpha Omega Alpha Society, graduating in 1959. After his internship at Boston City Hospital in 1960, he served three years as a lieutenant, Medical Corps, United States Navy, with service in Taiwan. He entered the Mayo Graduate School of Medicine in Rochester, Minnesota, in 1963 where he was a resident in medicine and subsequently a fellow in nephrology, being the recipient of the Edward John Noble Foundation Award. He was a member of the staff of the Mayo Clinic and an instructor, Mayo Graduate School of Medicine, from 1967 to 1970. In 1970 he became director of internal medicine for the Pensacola Educational Program in Pensacola, Florida, and a clinical assistant professor of medicine at the University of Alabama School of Medicine.

In 1972 Dr. Hall returned to his adopted State of Virginia where he joined the staff of the Memorial Hospital of Danville as its first nephrologist. He was a member of the Danville Urologic Clinic and became its first director of nephrology. He was chairman of the Department of Medicine, president of the medical staff, and director of medical education at the Memorial Hospital. He served in numerous capacities in the End-Stage Renal Disease Network. Dr. Hall was certified by the American Board of Internal Medicine and

was a fellow, American College of Physicians. He was also a member of the American Medical Association, Danville-Pittsylvania Academy of Medicine, American Society of Nephrology, Southern Medical Association, American Society of Internal Medicine and the Medical Society of Virginia.

Dr. Hall is survived by his wife, Virginia, and four sons. Scott is a 1992 candidate in the MD/PhD degree program at the University of Virginia. Steven is a radiology resident at the Medical College of Virginia. Stuart, with degrees in economics and business, is affiliated with the accounting firm of Coopers and Lybrand in Richmond. Stanley is a second-year medical student at the Medical College of Virginia.

In 1984 Dr. Hall founded the Piedmont Chapter of the National Kidney Foundation, the largest chapter in the State of Virginia. He spent countless hours in the development and organization of an annual golf tournament to benefit the Foundation. In memory of Dr. Hall, the Piedmont Chapter has renamed this tournament, the National Kidney Foundation-Dr. Jack W. Hall Memorial Golf Tournament.

Jack W. Hall was a consummate physician, held in the highest esteem and affection by his colleagues, patients and all who knew him. His presence among us will be greatly missed. In recognition of his achievements and to perpetuate his work, Dr. Hall's friends have established the Dr. Jack W. Hall Memorial Endowment of the Piedmont Kidney Foundation. Contributions to this fund may be sent to the Kidney Foundation, Box 3620, Danville VA 24543.

## Memoir of Jack Ulmer 1909-1990

*By William M. Eagles, MD*

Dr. Jack Lankford Ulmer died at his home in Richmond on November 22, 1990 following a fairly protracted illness at 81 years of age. He was born in Pascagoula, Mississippi, on January 6, 1909.

Dr. Ulmer received his bachelor's degree from Mississippi College in Clinton, Mississippi in 1933 and his MD from Vanderbilt School of Medicine in 1937. He had additional surgical and neurosurgical training at the University of Iowa and the Medical College of Virginia, and at Massachusetts General Hospital in neurosurgery under the chairmanship of Dr. James White.

During World War II he served as a neurosurgeon along with Dr. Frank Mayfield of Cincinnati at Percy Jones General Hospital in Battle Creek, Michigan. This hospital was serving as a peripheral nerve injury center, and here Dr. Ulmer became a true expert in this type of injury. He and Dr. Mayfield published a

"classic article" on sympathectomy in the treatment of causalgia. After the war, he returned to Richmond, where he was chief of neurosurgery at McGuire Veteran's Administration Hospital, remaining there until his retirement in 1979.

Dr. Ulmer was professor of neurological surgery at MCV and a visiting professor at the University of Virginia. He was a fellow of the American College of Surgeons and a member of the American Association of Neurological Surgeons, the Southern Neurological Society, the American Medical Association, the Medical Society of Virginia, the Richmond Academy of Medicine, and the Neurosurgical Society of Virginia.

Dr. Ulmer is survived by his wife, Mrs. Mary Christine Provine Ulmer; three daughters, Mary Ann Ulmer and Mrs. Sarah U. Wade, both of Richmond, and Mrs. Christine U. Moore of Arlington, Virginia; two sisters, Mrs. Sarah U. Perry of Asbury Park, New Jersey, and Mrs. Ruth U. Hewey of Cambridge, Massachusetts; and four grandchildren.

I find Longfellow's phrase, "footprints in the sands of time" particularly fitting. In the form of residents trained, Dr. Ulmer left footprints from the Atlantic to the Pacific Oceans. He will be remembered.

## Memoir of Jim Beaton 1915-1990

*By William L. Sager, MD*

Dr. James Duncan Beaton, general practitioner in Danville for 35 years, died in the Memorial Hospital, Danville, on November 16, 1990. He was 75. He had been in declining health since the previous January.

Born in Oyster Bay, New York, Dr. Beaton was a graduate of New York's Manhattan College and the Boston College of Physicians and Surgeons.

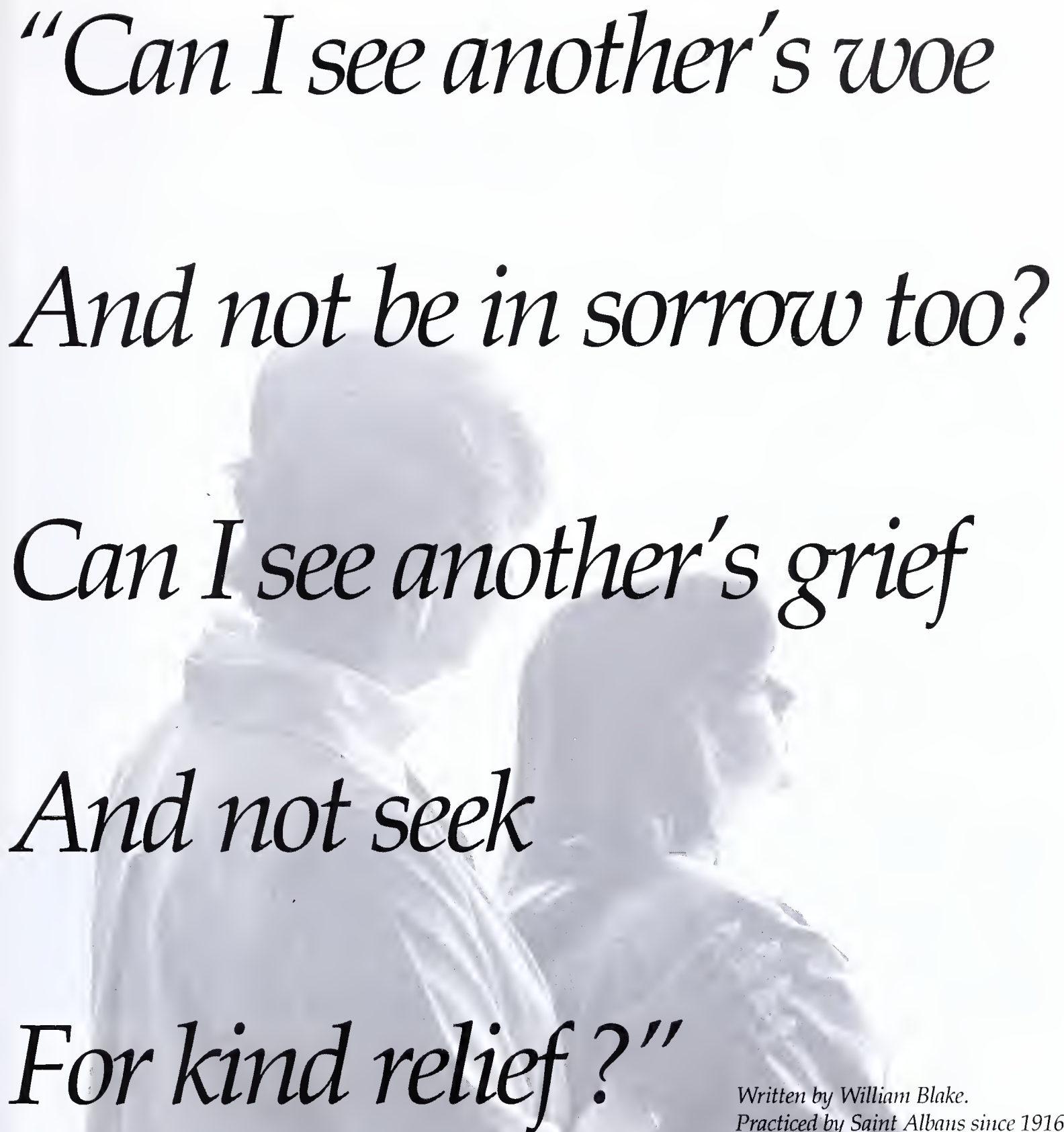
He was a member of Sacred Heart Catholic Church, the Medical Society of Virginia, the Danville-Pittsylvania Academy of Medicine, and the Danville Evening Lions Club.

He was first married to Leta M. Beaton, who died in June 1957. He later married Elgie Lewis Beaton who survives. Other survivors include two sons, James D. Beaton, Jr., of Maineville, Ohio, and Richard Crane Beaton of Gretna, Virginia; one sister, Mary Beaton of Saugerties, New York; and four grandchildren.

With no yen for the amassing of this world's goods, his trade-off was his free time. This he used in a leisurely pursuit of farming—his real relaxation.

Jim possessed a dry wit and enjoyed a good joke. His disarming smile further reinforced his down-to-earth approach to the practice of medicine.






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**Donald E. Haines, MD**, Cardiovascular Diseases, Box 158, University of Virginia Health Sciences Center, Charlottesville VA 22908

**Edward M. Spencer, MD**, Pediatrics, 1856 Field Road, Charlottesville VA 22903

**Janet E. Theby, MD**, Family Practice, Route 23, Box 430, Charlottesville VA 22901

## *Alexandria Medical Society*

**Andrea M. Jackson, MD**, Obstetrics/Gynecology, 315 S. Patrick Street, Alexandria VA 22314

## *Arlington County Medical Society*

**Robert P. Holman, MD**, Infectious Diseases, 1715 North George Mason Drive, Arlington VA 22205

## *Augusta-Highland County Medical Society*

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**Donna W. Newsome, MD**, Child Psychiatry, 2611 West Main Street, Waynesboro VA 22980

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## *Danville-Pittsylvania Academy of Medicine*

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## *Fairfax County Medical Society*

**Melanie J. Blank, MD**, Nephrology, 3349 Lakeside View Drive, Falls Church VA 22041

**Joseph L. Dunford, MD**, Emergency Medicine, 1001 Downshire Chase, Virginia Beach VA 23452

**Sonia M. Kheir, MD**, Dermatopathology, PO Box 188, Fairfax VA 22030

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*Mid-Tidewater Medical Society*

**Daniel C. Warren, MD**, General Preventive Medicine, Route 6, Box 7380, Gloucester VA 23061

**Roger A. Watkins, MD**, Internal Medicine, Route 3, Box 1075, Gloucester VA 23061

*Lynchburg Academy of Medicine*

**John H. Bell, MD**, Vascular Surgery, 2000 Tate Springs Road, Lynchburg VA 24501

**William A. Cook, III, MD**, Obstetrics/Gynecology, 2919 Confederate Avenue, Lynchburg VA 24501

**Eric R. Kenny, MD**, Rheumatology, 2025 Tate Springs Road, Lynchburg VA 24501

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*Continued on next page*

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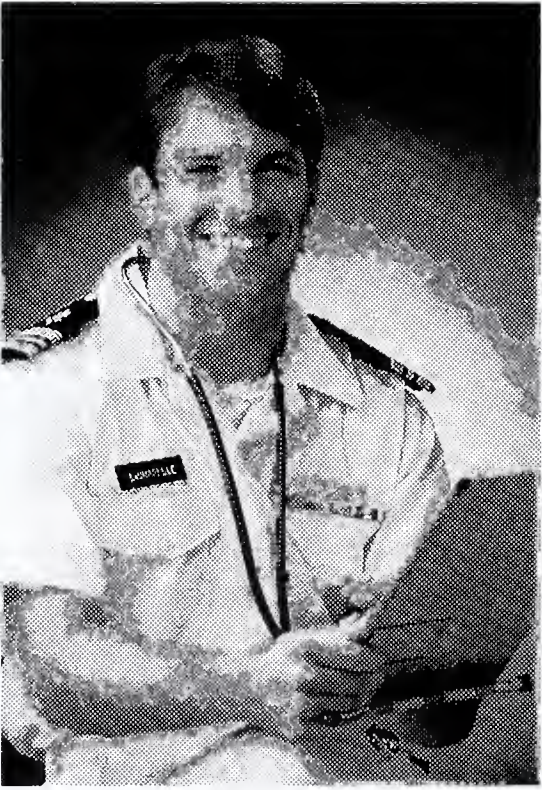
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**Gary M. Browning, MD**, Obstetrics/Gynecology, 844 Kempsville Road, Norfolk VA 23502

**Carl V. Bundschuh, MD**, Radiology, Sentara Norfolk General Hospital, Norfolk VA 23507

**Scott Clark, MD**, Anesthesiology, 2704 Royster Court, Virginia Beach VA 23454

**Daniel P. Croitoru, MD**, Pediatric Surgery, PO Box 11267, Norfolk VA 23517

**Richard S. Hoffman, MD**, Internal Medicine, 6826 Gardner Drive, Norfolk VA 23518

**Kathleen T. James, MD**, Anesthesiology, 2808 Ocean Mist Court, Virginia Beach VA 23454

**Thomas W. Lim, MD**, Anesthesiology, 12 Candlelight Lane, Portsmouth VA 23703

**Victor H. Mickunas, Jr., MD**, Pediatrics, 330 West Brambleton Avenue, Norfolk VA 23510

**Robert H. Schnarrs, MD**, Plastic Surgery, 508 Medical Tower, Norfolk VA 23507

### *Northern Virginia Medical Society*

**Cee Ann Davis, MD**, Obstetrics/Gynecology, 1870 Amherst Street, Winchester VA 22601

**Hartmut A. Doerwaldt, MD**, Family Practice, 115 South Church Street, Berryville VA 22611

### *Patrick Henry Medical Society*

**Maureen M. Aaron, MD**, Geriatrics, 938 Mulberry Road, Martinsville VA 24112

### *Prince William County Medical Society*

**David J. Wood, MD**, Child Psychiatry, 13649 Office Place, Woodbridge VA 22192

### *Richmond Academy of Medicine*

**N. Moses Adiele, MD**, General Preventive Medicine, 2101 Hopkins Road, Richmond VA 23224

**William D. Brickhouse, MD**, Orthopedic Surgery, 700 West Grace Street, Richmond VA 23220

**Martin D. Caplan, MD**, Cardiovascular Diseases, 110 North Robinson Street, Richmond VA 23220

**Judy L. Chin, MD**, Radiation Oncology, 3808 Thamesford Way, Richmond VA 23233

**James G. Ferguson, Jr., MD**, Ophthalmology, 2821 North Parham Road, Richmond VA 23294

**Mark P. Fritz, MD**, Anesthesiology, 2500 Olde Stone Road, Midlothian VA 23113

**Gregg L. Londrey, MD**, Vascular Surgery, 211 Banbury Road, Richmond VA 23221

**Gilberto E. Rodriguez, MD**, Allergy/Immunology, Box 225, MCV Station, Richmond VA 23298

**Donald M. Switz, MD**, Gastroenterology, Box 711, MCV Station, Richmond VA 23298

**Nicholas G. Tarasidis, MD**, Otolaryngology, 204 North Hamilton Street, Richmond VA 23221

**John W. Verheul, MD**, Family Practice, 2654 Mohawk Drive, Richmond VA 23235

**Howard O. Wiles, III, MD**, Obstetrics/Gynecology, 901 Hioaks Road, Richmond VA 23225

### *Roanoke Valley Academy of Medicine*

**George A. Abraham, MD**, Allergy/Immunology, 1030 South Jefferson Street, Roanoke VA 24016

**William H. Craft, Jr., MD**, Pediatrics, Box 12946, Roanoke VA 24029

**A. Paul Dallas, MD**, Internal Medicine, Roanoke Memorial Hospital Box 13367, Roanoke VA 24033

**Lawrence I. Kleiner, MD**, Neurological Surgery, 5304 Indian Grave Road, Roanoke VA 24014

### *Southside Virginia Medical Society*

**Sharad N. Saraiya, MD**, Orthopedic Surgery, PO Box 140, Hopewell VA 23860

### *Southwestern Virginia Medical Society*

**James P. Culley, MD**, General Surgery, 1409 Wenonah Avenue, Pearisburg VA 24134

### *Williamsburg-James City County Medical Society*

**John A. Kona, MD**, Orthopedic Surgery, 1155 Professional Drive, Williamsburg VA 23185

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# MEETINGS

**1991 Annual Meeting,  
The Medical Society of Virginia,  
November 6-10, Williamsburg**

**October 31-November 2**

**Practical Dermatology for the Primary Care Physician** (Eastern Virginia Medical School), *San Antonio, Texas*. Jeanette Schmitz, 804-446-6143.

**October 31-November 3**

**Advances and Controversies in Internal Medicine** (Lloyd Noland Hospital), the Greenbrier, *White Sulphur Springs, West Virginia*. Dr. George M. Converse, 205-783-5276.

**November 1-2**

**Progress in Pediatrics** (Johns Hopkins), *Baltimore*. 11 credit hrs. Fee: \$140. CME Office, 301-955-2959.

**November 5**

**Regular Meeting of the Medical Society of Virginia's Council.** *Williamsburg*. James L. Moore, Jr., 804-353-2721.

**November 7-10**

**16th Edition, Practical Dermatology for the Primary Care Physician** (Eastern Virginia Medical School), Rivercenter Marriott, *San Antonio, Texas*. CME office, 804-446-6140.

**November 16-19**

**85th Annual Scientific Assembly of the Southern Medical Association**, *Atlanta, Georgia*. SMA, 1-800-423-4992.

**December 5-7**

**Advances in Obstetrics and Gynecology** (Medical College of Virginia), *Richmond*. CME Office, 804-786-0494.

**December 6**

**Neurological Problems of Infancy and Childhood** (Eastern Virginia Medical School), Fort Magruder Inn, *Williamsburg*. CME Office, 804-446-6140.

**December 7**

**8th Annual Clinical Update in Pulmonary Medicine** (Center for Bio-Medical Communication, Inc./Deborah Heart and Lung Center), *Atlantic City, New Jersey*. 7.25 credit hrs. CBC, 201-385-8080.

**December 8-11**

**AMA House of Delegates Interim Meeting.** *Las Vegas, Nevada*. James L. Moore, Jr., 804-353-2721.

**January 12-17**

**Gastroenterology Update: Surgical and Medical Advances** (Johns Hopkins), *Vail, Colorado*. 20 credit hrs. Fee: \$450. CME Office, 301-955-2959.

*Continued over*

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#### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## MORE MEETINGS

**January 16-18**

**Annual Conference, American Academy of Pain Medicine,** Scottsdale, Arizona. 708-966-9510.

**January 22-25**

**Adolescent Medicine Seminar (Lloyd Noland Hospital), Walt Disney World, Florida.** CME Office, 205-783-5276.

**January 31-February 2**

**Annual Meeting of the Virginia Neurological Society, the Homestead, Hot Springs.** Donna Scott, 804-353-2721.

**February 3-8**

**19th Annual Geriatric Symposium: a Board Review (Johns Hopkins), Baltimore.** 36 credit hrs. Fee \$570. CME Office, 301-955-2959.

**February 23-28**

**6th Annual Innovations in the Diagnosis and Treatment of Gastrointestinal Disorders (Georgetown University Medical Center), Snowmass, Colorado.** CME Office, 202-687-8735.

**March 13-15**

**Systems Review of Geriatric Medicine (Medical College of Virginia/VCU), Williamsburg.** CME Office, 804-786-0494.

**March 15-18**

**Internal Medicine Seminar (Lloyd Noland Hospital), Walt Disney World, Florida.** CME Office, 205-783-5276.

**March 18-21**

**Pediatrics Seminar (Lloyd Noland Hospital), Walt Disney World, Florida.** CME Office, 205-783-5276.

**March 28-April 1**

**Comprehensive Review of Clinical Obstetrics and Gynecology (Georgetown University Medical Center), Washington, DC.** CME Office, 202-687-8735.

**April 1-5**

**General Surgery Update (Lloyd Noland Hospital), Hilton Head Island, South Carolina.** CME Office, 205-783-5276.

**April 3-5**

**7th Annual Review Course in Reproductive Endocrinology and Assisted Reproduction (Eastern Virginia Medical School), Pentagon City, Virginia.** Jeanette Schmitz, 804-446-6140.

**April 3-5**

**12th Annual Ophthalmology Conference (Medical College of Virginia/VCU), Williamsburg.** CME Office, 804-786-0494.

**April 9-12**

**13th Clinical Electrocardiography: Basic Concepts and Interpretation (Eastern Virginia Medical School), Williamsburg.** Jeanette Schmitz, 804-446-6140.

*Continued on page 263*



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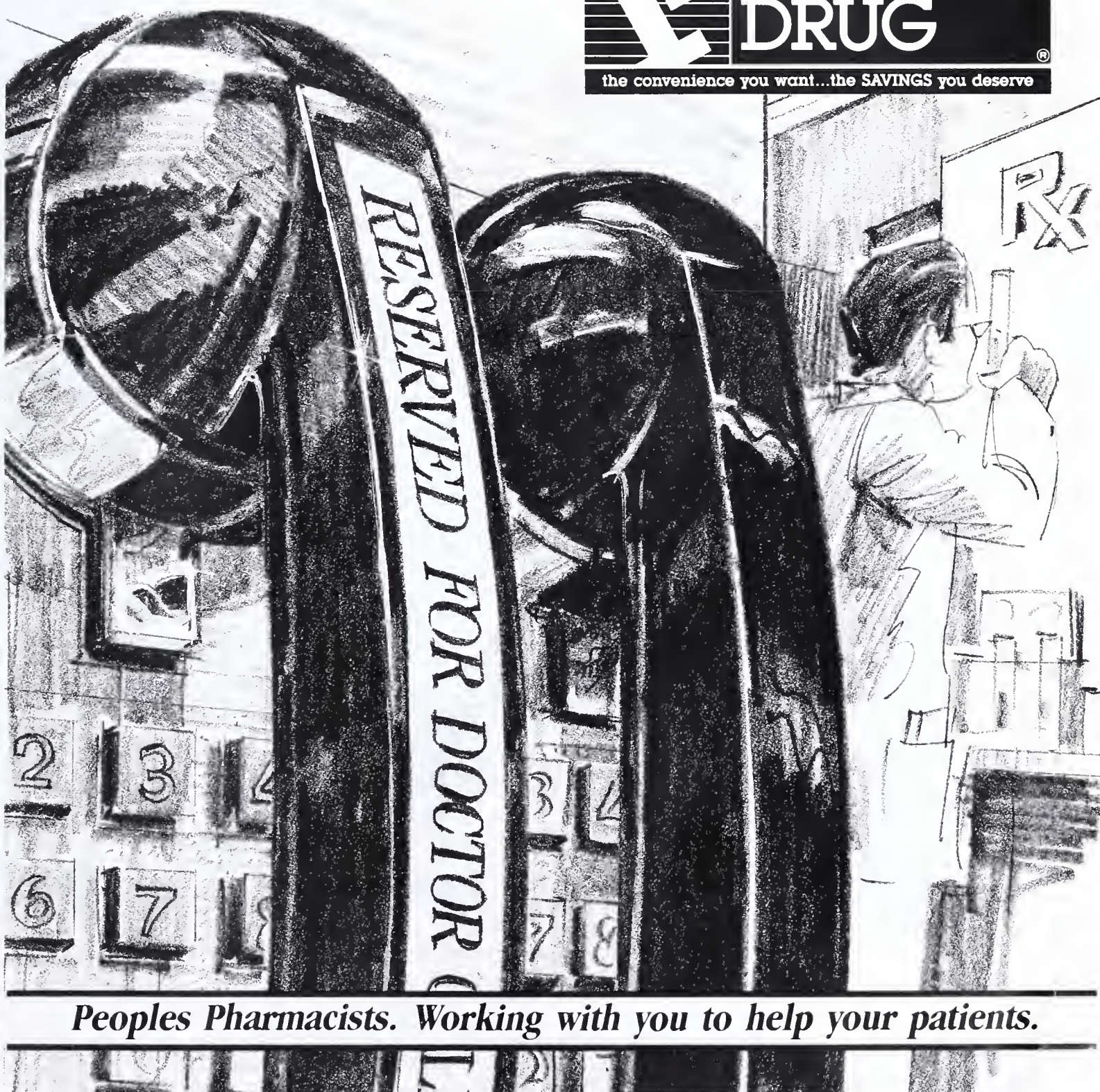
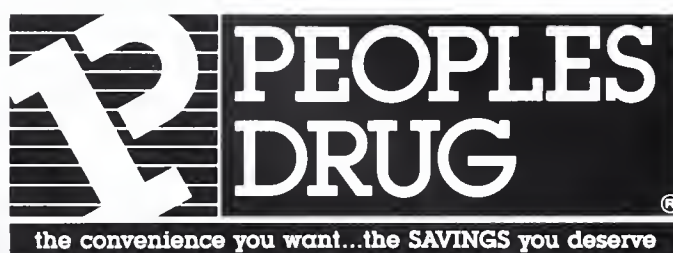
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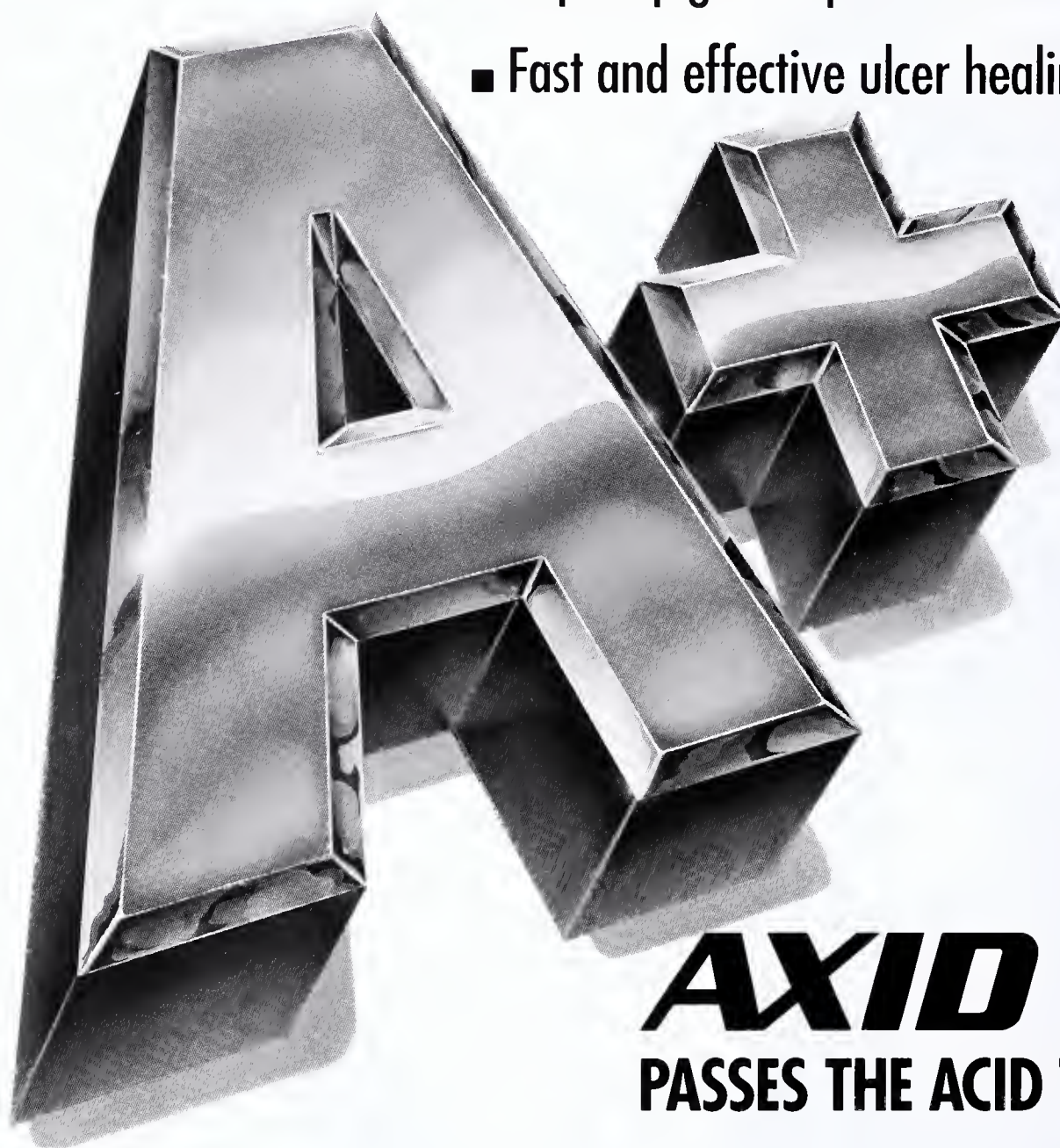


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**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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**References**

1. Data on file, Lilly Research Laboratories.
2. Scand J Gastroenterol. 1987;22(suppl 136):61-70.
3. Scand J Gastroenterol. 1987;22(suppl 136):47-55.
4. Am J Gastroenterol. 1989;84:769-774.

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**MORE MEETINGS**

**April 10-12**  
**14th Annual Emergency Medicine for the Primary Care Physician Conference** (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

**April 12-15**  
**20th Annual Meeting of the North American Primary Care Research Group** (Medical College of Virginia/VCU), *Richmond*. CME Office, 804-786-0494.

**April 24-26**  
**Annual Meeting of the Virginia Orthopaedic Society**, *Arlington*. Donna Scott, 804-353-2721.

**April 24-26**  
**27th Annual Pediatric Springfest** (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

**April 30-May 2**  
**Annual Meeting of the Virginia Society of Otolaryngology/Head and Neck Surgery**, *Charlottesville*. Donna Scott, 804-353-2721.

**May 1-3**  
**12th Annual Clinical Concerns in Primary Care** (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

**May 1-4**  
**Annual Meeting of the American Society for Clinical Investigation**, *Baltimore*. Louise Rappaport, 609-848-1000.

**May 7-10**  
**17th Edition Practical Dermatology for the Primary Care Physician** (Eastern Virginia Medical School), *Atlanta, Georgia*. Jeanette Schmitz, 804-446-6140.

**May 7-10**  
**Annual Meeting of the Virginia Chapter of the American College of Radiology**, the Homestead, *Hot Springs, Virginia*. Patricia R. Berry, 703-669-8312.

**May 14-16**  
**Annual Meeting of the Virginia Society of Ophthalmology**, *Richmond*. Donna Scott, 804-353-2721.

**May 23-25**  
**13th Annual Urogynecology and Pelvic Surgery Conference** (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

**June 1-5**  
**8th Annual Family Medicine Review Course** (Eastern Virginia Medical School), *Virginia Beach*. Jeanette Schmitz, 804-446-6140.

**June 2-6**  
**General Surgery Seminar** (Lloyd Noland Hospital), *Hilton Head Island, South Carolina*. CME Office, 205-783-5276.

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**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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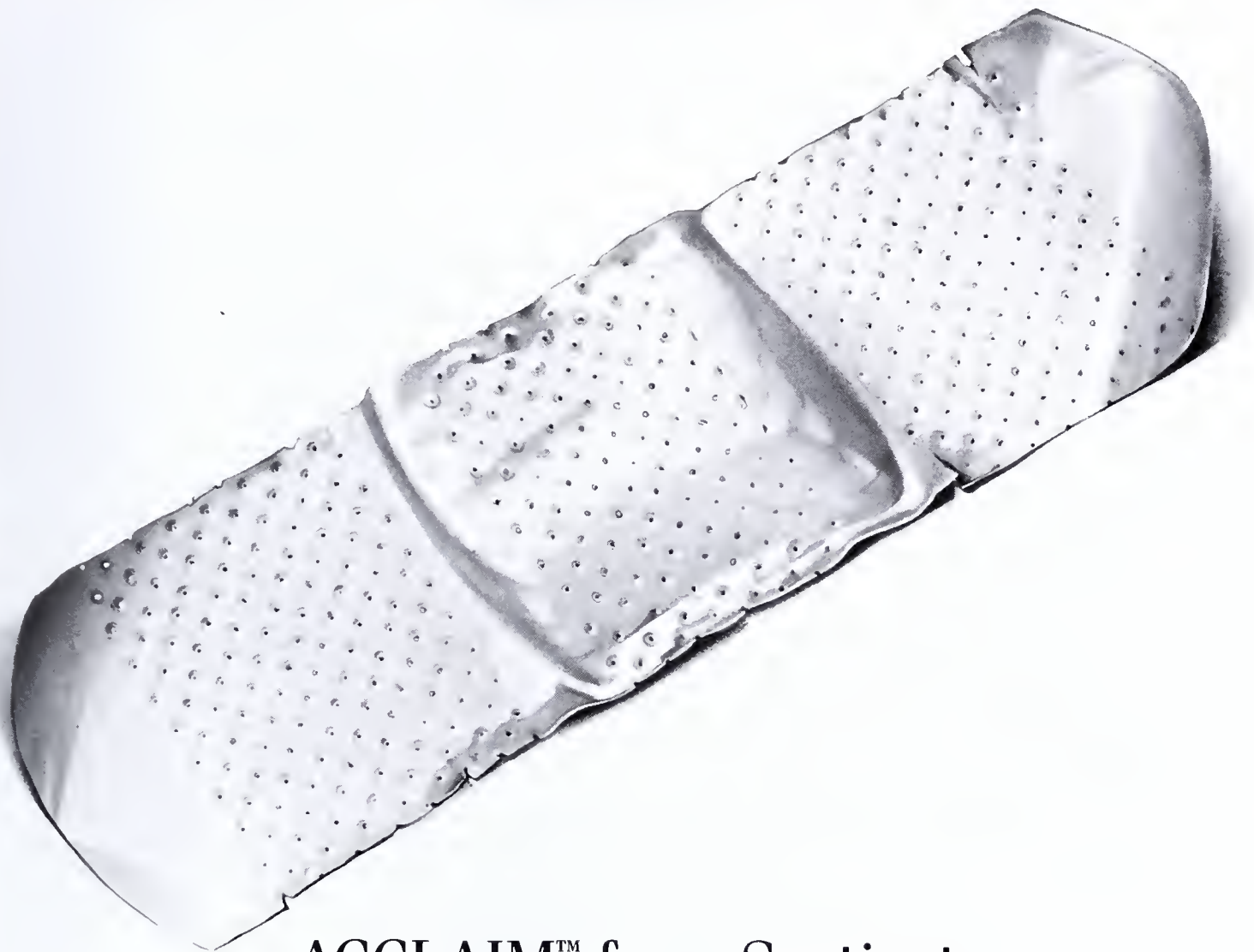


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# VIRGINIA MEDICAL *quarterly*

Volume 119/Number 1  
 Winter 1992 (Jan/Feb/Mar)

## THE ANNUAL MEETING

**On the Cover:** At the Medical Society of Virginia's 144th Annual Meeting, delegates stand to applaud the address of President John Owen. *Photographs by Skip Baker*

### From the Rostrum

- 18 "A year's supply of stationery ran out in June."  
 JOHN A. OWEN, JR.
- 22 "To serve our patients and honor our profession"  
 GEORGE E. BROMAN
- 24 "In the changes ahead, be either a participant or a victim."  
 JOHN W. HOLLOWELL
- 28 "Can George Bush be beaten? Yes! Are term limits a good idea? No!"  
 LARRY J. SABATO
- 30 "A pattern of influencing health legislation"  
 EILEEN THOMASON
- 30 **Actions of the House of Delegates** Results of the 117 resolutions and recommendations considered by the House
- 38 **Winners** Dr. Robert L. E. Keeley wins the Community Service Award. Other awards, honors, prizes.
- 55 **New Medical Society of Virginia Officers 1991-1992**

## SPECIAL REPORT

- 13 **The Physician in Litigation** THOMAS P. COX

## MEDICINE

- 42 **Clinicopathology Conference: Polymyositis and a Thalamic Mass**  
 Discussed by EUGENE C. CORBETT, JR.
- 48 **A Winning Indigent Care Program**  
 SAMUEL T. SELDEN and NANCY M. WELCH
- 49 **Public Safety: Virginia's Impaired Drivers**  
 HOWARD MCCUE, JR.

*continued over*

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## EDITORIALS

- 52 President Hollowell
- 54 Kudos E. L. KENDIG, JR.
- 54 To Ease Costs, Give and Take JUAN M. MONTERO II
- 55 Appointment Blooper E. L. KENDIG, JR.

## OBITUARY

- 56 Memoir of Simon Russi ALVIN COHEN
- 56 Memoir of Weir Tucker JAMES A. SHIELD, JR.
- 57 Memoir of Samuel W. Budd WILLIAM S. DINGLEDINE
- 57 Memoir of John Earle Smith TONY CONSTANT, JR.

## DEPARTMENTS

- 10 Who’s Who
- 60 New MSV Members
- 62 Meetings about Medicine
- 66 Classified Advertisements

## INDEX TO ADVERTISERS

Associated Builders .....Cov 2	National Diagnostic Oncology....6
C. W. Albertson.....65	Palisades Pharmaceuticals .....64
Clements & Company .....16	John P. Pearl & Associates.....15
Coastal Emergency Services	Richmond Headache Center.....17
of Richmond.....66	Riverside Laboratories.....65
Cumberland Hospital.....8-9	Saint Albans Hospital .....51
The Doctors Company.....41	The Saint Paul .....5
Doctors Insurance Reciprocal ..12	G. D. Searle & Company ...Cov 4
Health of Virginia .....50	Sentient Systems .....1
Institute for Chronic Pain	State Volunteer Mutual
Management.....6	Insurance Company .....2
Knoll Pharmaceuticals .....6-7	Sun Room Company.....62
Lewis-Gale Clinic .....11	United States Air Force .....16
Lilly & Company.....58-59	United States Air Force
Lloyd Noland Hospital .....63	Reserve.....66
Lynchburg Emergency	United States Navy .....65
Physicians .....67	Vein Clinics of America .....14
Medical Protective Company ...61	WMI Medical Services.....17



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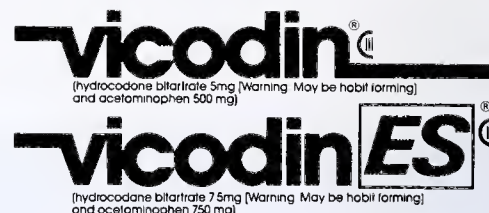
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**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.

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**Allergic-Type Reactions:** VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

### PRECAUTIONS:

**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

### Usage in Pregnancy:

**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

**Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

### DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

### OVERDOSAGE:

**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised June 1989

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COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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1. Data on file, Knoll Pharmaceuticals

2. Standard industry new prescription audit

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And, because recreation is an important part of head injury therapy, Cumberland makes sure its patients spend time in creative play, exercise and recreational therapy—on the playground and in the gym. At Cumberland kids can still be kids.



## Cumberland Has Successful Experience Treating Head-Injuries

Cumberland is a JCAHO-accredited hospital, with eight years' experience treating patients with all levels of head injuries. This table shows the percentage of patients admitted to Cumberland at each RLA level during the past three years:

RLA Level 1	2.0%
RLA Level 2	45.0%
RLA Level 3	16.8%
RLA Level 4	15.7%
RLA Level 5	5.3%
RLA Level 6	5.2%
RLA Level 7	6.3%
RLA Level 8	3.2%

In addition, Cumberland has the experience treating young patients with many types of head injuries. This table shows the percentage of patients admitted with head injuries resulting from the following causes:

Automobile accident	44.0%
Pedestrian accident	15.2%
Bicycle accident	8.2%
ATV accident	5.3%
Skateboard	2.1%
All others	30.4%

## Cumberland's Staff

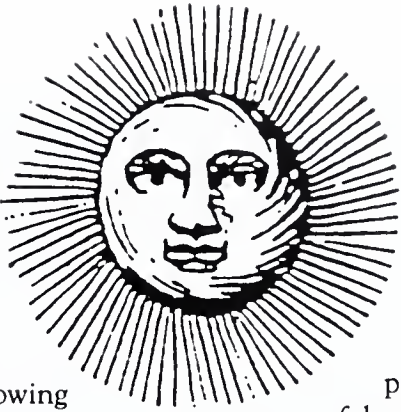
Because Cumberland is a hospital, and not just a rehab center, you can be confident that treatment is delivered by licensed rehabilitation professionals and other accredited hospital staff, all under the direction of an admitting physician. All physicians on Cumberland's admitting staff are board-certified in their specialty, and dedicated to the treatment of head-injured patients. The staff includes Donald A. Taylor, M.D., *Pediatric Neurologist*, Michael J. Decker, M.D., *Physiatrist*, Daniel N. Davidow, M.D., *Pediatrician*, and James E. Sellman, M.D., *Pediatric Psychiatrist*.

## Cumberland Hospital's Quiet Country Setting

Cumberland Hospital is located on a quiet, college-like campus that spans some 1,200 acres, just a few miles from Colonial Williamsburg and Jamestown. Healthy, outdoor activities—such as walking, hiking, and fishing—all available right here on the Cumberland campus are part of our comprehensive rehabilitation program.

Here, patients and their families can escape the hectic pace of everyday life and refocus their lives on the rehabilitation process.

At dawn and dusk, deer can often be seen grazing at the edge of the woods around the hospital, and flocks of Canada geese stop by to feed and rest on their journeys North and South.



# Cumberland Patients Recover

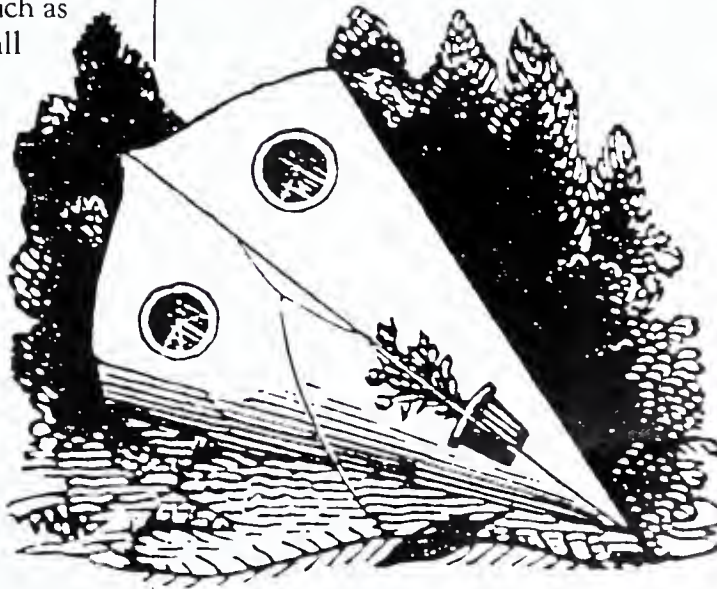
Cumberland has a proven record of successful treatment and recovery with head-injured patients. In a recent study conducted jointly with the Medical College of Virginia Hospitals, of 36 patients at RLA 4 or below who were admitted to Cumberland within 180 days post-injury, 22 made substantial improvement of two or more levels on the RLA scale, while 9 of the remaining 14 patients improved by one RLA level. In the same study, it was noted that 10 of 16 patients admitted 180 days post-injury in a vegetative state improved by two or more levels on the RLA scale.

## Cumberland Knows You Want Only the Best for Your Patients

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Cumberland Hospital for Children and Adolescents  
New Kent, Virginia





# WHO'S WHO

**Dr. Mason C. Andrews**, professor of obstetrics and gynecology at Eastern Virginia Medical School, has been named president-elect of the American Obstetrical and Gynecological Society. Dr. Andrews, one of the founding fathers of EVMS and the renowned Jones Institute, is to be installed in September of 1992. He has been president of the Norfolk Academy of Medicine and the Virginia and American Ob-Gyn Societies. A civic leader in Norfolk, he is a long-time Norfolk city councilor and former vice-mayor. In 1989 he received The Medical Society of Virginia's Community Service Award.

**Dr. David M. Smith** is the new president of the Lynchburg Academy of Medicine. The new secretary is **Dr. Glenn I. Meadows, III**.

**Dr. Timothy L. Kelly, Jr.**, McLean, is the Arlington County Medical Society's 1991 Welburn Award winner, given for "outstanding service and leadership to his profession and community." A urologic surgeon, Dr. Kelly is a past president of the Arlington County Society, the Catholic Physicians Guild of Northern Virginia, the Washington Urologic Society, the Northern Virginia Academy of Surgery, and the medical staff of Arlington Hospital, where he also has served as a member of the board of trustees. In 1986 Georgetown University named the Timothy L. Kelly Urology Library in his honor.

**Dr. Charles H. Crowder, Jr.**, South Hill, has been elected to serve on the board of directors of Virginia's statewide Area Health Education Center.

For his "long-time involvement and commitment to the betterment of the practice of medicine," the

American Society of Internal Medicine has given its special recognition award to **Dr. Robert K. Heide**, Norfolk. Dr. Heide is an assistant professor of internal medicine at Eastern Virginia Medical School and a past president of the Virginia Society of Internal Medicine.

New president of the Washington DC Chapter, American Society of Psychoanalytic Physicians, is **Dr. Edmund P. Naccash**, Fairfax.

**Dr. William Whitehurst Old III**, Lexington, has closed the general surgical practice he has conducted in Lexington since 1959 but intends to continue as post surgeon at Virginia Military Institute. He has practiced in Lexington in association with Drs. Robert P. Irons Jr. and Sr. at the Rockbridge Surgical Clinic and is a former president of the staff of Stonewall Jackson Hospital.

**Dr. James L. Lynde**, Lynchburg, was named a fellow of the American College of Radiology at the ACR's annual meeting in Minneapolis.

Members of the Southwestern Virginia Medical Society have elected **Dr. W. Wade Perry**, Galax, as president, and **Dr. Karen L. Quinn**, Shawsville, as secretary.

**Dr. Norman R. Tingle, Sr.**, general practitioner in Lively for 40 years, was awarded the Community Builders Award by the Lancaster Union Masonic Lodge during the lodge's annual dinner and banquet for "his commitment to his community and church and his kindness to others." No stranger to awards, Dr. Tingle has been given the Service Award of the Lancaster School Board and the Outstanding Citizen Award of the Kilmarnock-Irvington-White Stone Rotary Club. A native of Virginia's

Northern Neck, he is a graduate of the University of Virginia and the Medical College of Virginia.

**Dr. David W. Seamon**, Martinsville, has been elected a fellow of the American Academy of Pediatrics.

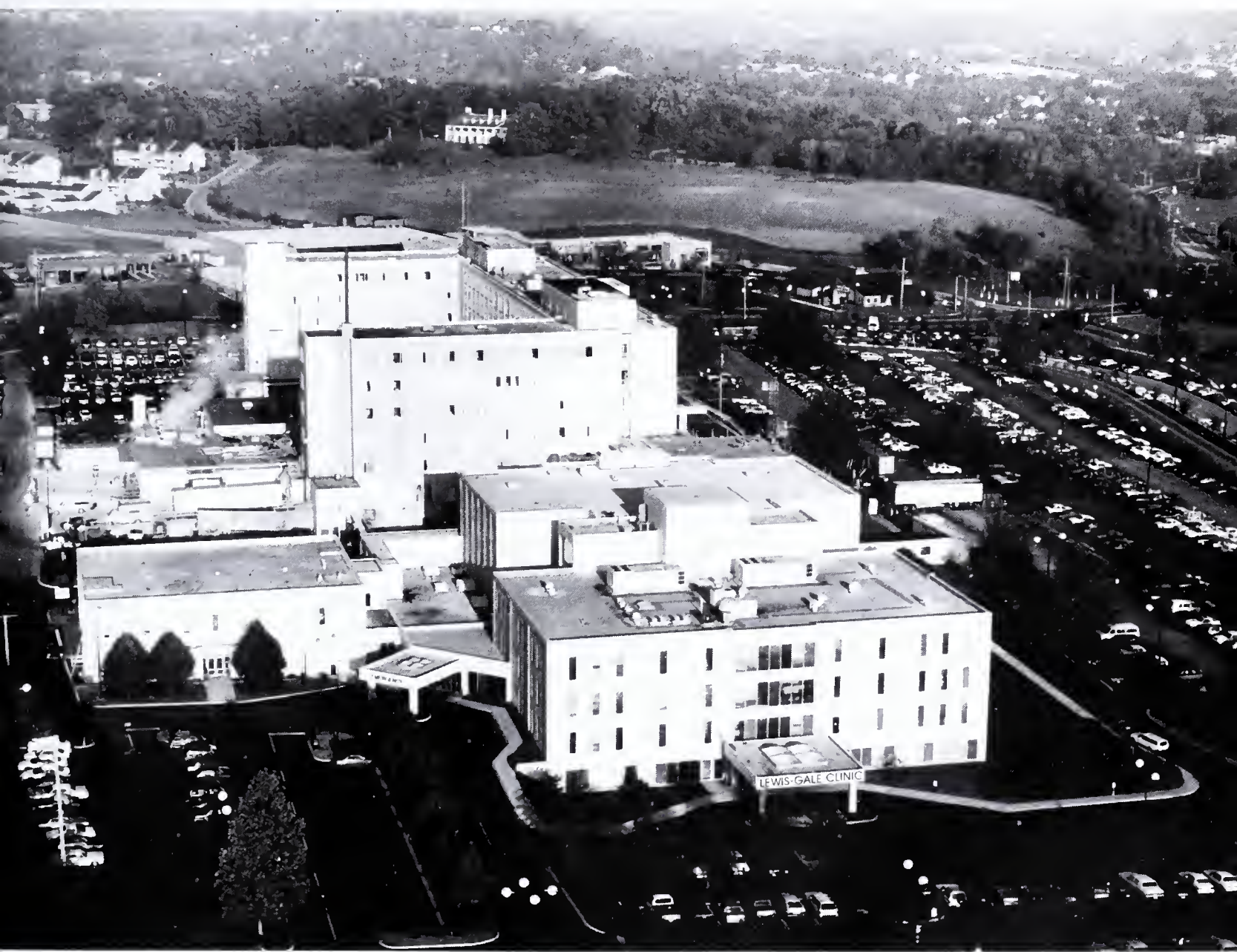
**Dr. Frank A. Pettrone**, Arlington, visited China recently as the team physician for the U.S. women's national soccer team. He accompanied the team to Beijing, Changchun, Yanji, and Anshan for four matches held in preparation for the World Cup held in China the following month. Dr. Pettrone has worked with the Olympic soccer and hockey programs. As George Mason University's team doctor, he helped develop Abdi Bile into a world champion 1500-meter runner.

From Macon, Georgia, comes word that **Dr. Bernard M. Williams**, who formerly practiced in Waynesboro, Virginia, was the recipient of the Mental Health Profession Award for 1991 at the annual convention of the Georgia Alliance for the Mentally Ill. Dr. Williams "is always ready to help families, patients, and other mental health professionals," read the citation accompanying the award, "and continuously works to increase the public's knowledge about mental illness and reduce the stigma encountered by those who suffer from it." Dr. Williams has been practicing psychiatry in Macon for the past six years. He is a fellow of the American Psychiatric Association and a member of the Georgia Psychoanalytic Physicians.

A member of VaMPAC's board of directors, **Dr. Roger W. Littwiler** of Roanoke has been appointed chairman of the American Society of Anesthesiologists' political action committee.



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## The Physician in Litigation

# Guidelines for Helping a Fellow Professional in a Time of Need

**L**itigation is an emotionally trying time for a physician, both personally and professionally. It can be a challenging time as well for the physician's peers, who may not know how to act around their colleague or what to say, and may also have to cope with such thoughts as "Is he a bad physician?", or "I wonder if she really was negligent," or (most commonly) "There but for the grace of God go I."

This article offers ways of assisting a colleague to cope with the stress of litigation.

First and foremost, steer clear of any discussion of the specifics of the case, lest you become a potential witness for either peer or plaintiff. Concentrate on being supportive and, if possible, offer coping assistance.

Your main contribution may be nothing more than being a good listener. Listening is active and involves using not just the ears, but the eyes, mind, heart, skin and guts. To listen well you must set aside preoccupations with other thoughts or activities and occupy yourself solely with the speaker. You must pay attention not just to what is being said, but how it is being said. You must make an effort to hear what is not being said, what is only implied or hinted at or perhaps held back. You must concentrate on the information you are receiving and with it formulate an opinion and response.

The assumed goal of listening is understanding, which, like listening, can be learned, practiced and improved upon. One way to understand a person is to read about, or hear others speak about, that person. Another, more common way of

understanding is through our own eyes, using our own internal frames of reference, so that we do or do not understand someone in terms of our own background, education and experience.

A third way of understanding is the most difficult, the most rewarding, and potentially the most beneficial to the physician in litigation. Carl Rogers refers to this way as "understanding with another person."<sup>1</sup> It means trying to understand what it is like to be the other person, to see the world through the other person's eyes and interpret it as the other person does. This is "empathy," and while sympathizing with the physician in litigation can be beneficial, empathizing can help him much more. As previously warned, the specifics of the case should not be discussed, but internal thoughts and feelings can be explored empathetically and on the defending physician's terms.

It may be difficult for the physician in litigation to talk about his predicament. Here are some ways to signal encouragement:

**Silence.** Non-verbal gestures can indicate to someone that you are listening and want that person to talk.

**"Mm-hm."** This common affirmative sound usually indicates that the listener wants the speaker to continue.

**Restatement.** Echoing the speaker's words may keep the speaker going. For example, the physician in litigation says, "I feel cold and deserted." You restate, "You feel cold and deserted."

**Clarification.** This can mean summarizing a speaker's words as when the physician-defendant says, "The only thing that is clear to me now is

that I am mixed up. I look at every patient as though they want to pick my pocket and I don't know if I even want to continue in medicine." You respond, "You're mixed up and don't know if you want to continue practicing medicine."

Or there can be a need to make something clearer, as when the physician in litigation says, "I mean, I am just stuck in a trick bag and really tired of feeling like a defendant with every patient I see. I almost feel like bagging the whole garbanzo." You might comment, "You lost me a couple of times there. What do you mean by . . .?"

**Positive Thought.** Anything said to move the physician-defendant towards positive thought is beneficial. For instance, in response to "I just don't think I can practice medicine anymore," you could state, "I've watched you work and I disagree with you" or "I doubt if you'll feel that way in six months, but if you don't try, you'll never know, will you?"

These are just a few ways of helping the physician in litigation to engage in open discussion. Anything that works is good.

Striving to listen well and empathize with a physician who is under stress from litigation is not one of the easiest tasks in the world, but it can be one of the most rewarding. It is rewarding to the physician-defendant because 1) it reduces feelings of isolation, and 2) it encourages verbalizing, and even confronting, the attendant fear. It can be rewarding to you because it enables you to help a fellow professional in a time of need.

—THOMAS P. COX

1. Rogers C. On Becoming a Person. Boston, Houghton Mifflin Co., 1961

The author is a risk management consultant with the Virginia Insurance Reciprocal and The Doctors Insurance Reciprocal.

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*D.K., a 69-year-old woman with recurrent ulcer and history of skin graft failures, on initial day of treatment. Edema of ankle and inflammation clearly visible.*

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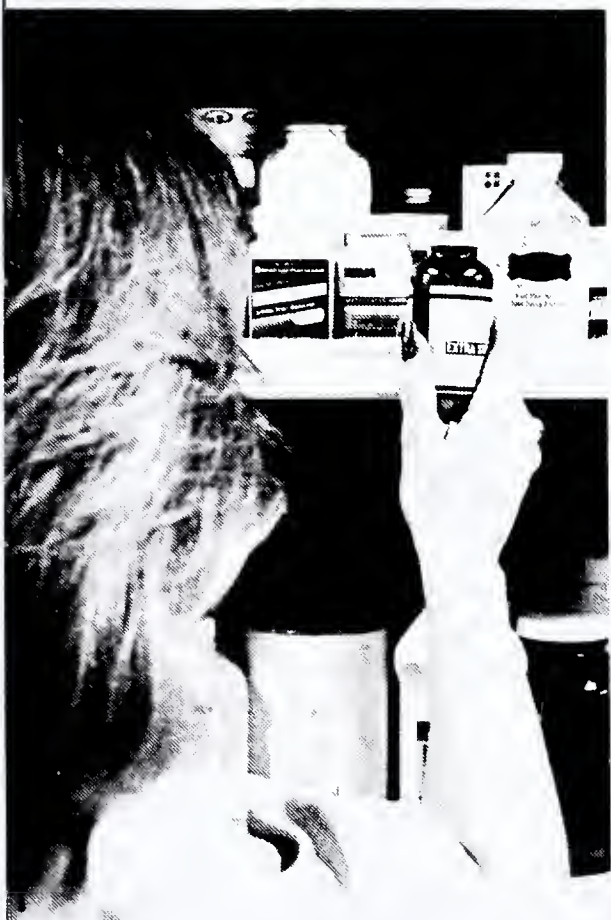
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# From the Rostrum

The texts of speakers at the 144th Annual Meeting of The Medical Society of Virginia reflect the concerns of the physicians who attended that meeting.

Inserted at the centerfold is a pullout section summarizing the outcomes of the 51 resolutions and 66 recommendations considered by the House of Delegates.

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## JOHN A. OWEN, JR.:

“A year’s supply of stationery ran out in June.”

**L**ADIES AND GENTLEMEN, I come before you today to render an accounting of the last twelve months of our Society, and to express my thanks to you for the privilege of presiding during that period. Every president on this occasion expresses deep appreciation for having been given the honor of leading The Medical Society of Virginia, and with that I agree 100%. Let me go one step further: if I had it all to do over again, knowing what I know now—I’d be the happiest man in the world. I have enjoyed it more than you could possibly imagine.

The enjoyment is directly related to the time I’ve spent, sleeves rolled up, working side by side with the many talented and dedicated people on our staff, busy with more projects than I had ever imagined. MSV efforts that are helping us all. Your staff is a great team, and they deserve great fans. This year marks the twenty-fifth year of service of Mr. Moore to our Society and I consider it his best year yet. As you know, we have two new people on the staff these days, Paul Galanti as Deputy Executive Vice President and Madeline Wade as Director of Governmental Affairs and Executive Director of VaMPAC. Sandy Kramer has

moved to Dover Road to work full-time as our General Counsel; keeping tabs on all of the health related activities, committees and agencies is a full-time job, and she does it in outstanding fashion. Indeed, we have all worked together in a very collegial, happy, and productive atmosphere and I predict that next year’s productivity will make it obvious to everyone how sorely we have needed these staff additions.

I would like to express also my thanks to my parent institution, the University of Virginia. The Dean of the School of Medicine, Dr. Robert Carey, kindly saw fit to consider this a sabbatical for me and continued my salary unabated even though I have spent at least half my time on Medical Society of Virginia business. Since I lost no income, this removed the necessity of the usual president’s allowance. Subtracting \$5,500 used to support secretarial activities, we have been able to save almost \$10,000 for the Society. I am sure there are those who will say you get what you pay for, so I will say it first and leave it at that.

**A**T OUR LAST annual meeting we heard a very troubling and depressing discussion of

Delivered before the House of Delegates on November 7, 1991, during The Medical Society of Virginia’s Annual Meeting in Williamsburg.



the economics of national health care. During the last twelve months we have heard these same lamentations delivered over and over by various people in various contexts. Everybody agrees that our current health policy needs a lot of work, but we are slow to come together to think constructively. The newsmakers, the political pundits, and the speechifiers are still in the phase of trying to find a scapegoat and punish him rather than facing the fact that there is no scapegoat, but a complex situation that demands sacrifice on the part of everyone. I predict that by the next year or so one of the chief scapegoats will be the medical profession and we will all develop intractable emesis from the ubiquitous outcry that we are "the only profession that can dictate both the demand and supply for expensive services."

What a difference the deficit makes! Many of us remember back in the late 60's, right after Medicare was enacted, when there was universal public concern because of the doctor shortage, and concerted action to provide more doctors to take care of more sick people quickly. Twenty-five years later, in the vocabulary of HCFA, a doctor is defined as someone who generates \$200,000 in health costs per year. Taking care of sick people has become irrelevant.

This is the basic ethical problem that I tried to explain to our congressional delegation at the time of our visit last May and I think they listened and heard what we were saying. Certainly when we went back in July to talk to them all about the RBRVS situation they were courteous, receptive, and completely cooperative. I think I can fairly say that we have better rapport with our national legislators than ever before. We must do everything in our power to preserve that. We must not slant our message to coerce their agreement. The battle over the behavioral offset has been a very crucial one,

perhaps more so than you realize, and it's not over yet. It is either a Stalingrad or a Guadalcanal, and we can only hope it is not a Verdun.

Last July I asked every doctor in Virginia to write his or her congressman and to project personally what would happen if Medicare reimbursement were slashed 16%. How many of you wrote such a letter? What did you say you would do about the volume of Medicare patients you would see? I hope you remember, because your Congressmen surely will. They have stuck their necks out for you. If they find that, having fulminated against the idea of behavioral offset, you turn right around and double your volume of service to maintain current income—they will never believe you again. And they will be right. The Bible extols the man "who sweareth to his own hurt, and changeth not." That you learned in Sunday School, and in kindergarten you learned to keep your promises. That's all you need to know.

My view of all this is quite simplistic. Our national health policy needs a lot of change right now, and will need continuing change every year until the end of time. Every change that is proposed will require a trade-off in terms of services versus costs. The medical profession can and should have a powerful voice in recommending these trade-offs, but in the end it is the people who will decide. For them to decide wisely, they will need understanding, and that requires that we devote some time to educating a nation notorious for its extremely short attention span.

**N**OW LET'S TALK about the state of The Medical Society of Virginia. The Council, the staff, Dr. Hollowell and I have all tried to keep busy. I take a modest pride in the fact that what is ordinarily a year's supply of stationery for the President ran out in June. Also by virtue of my possession of a



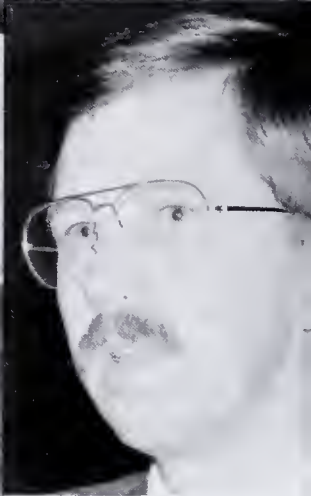
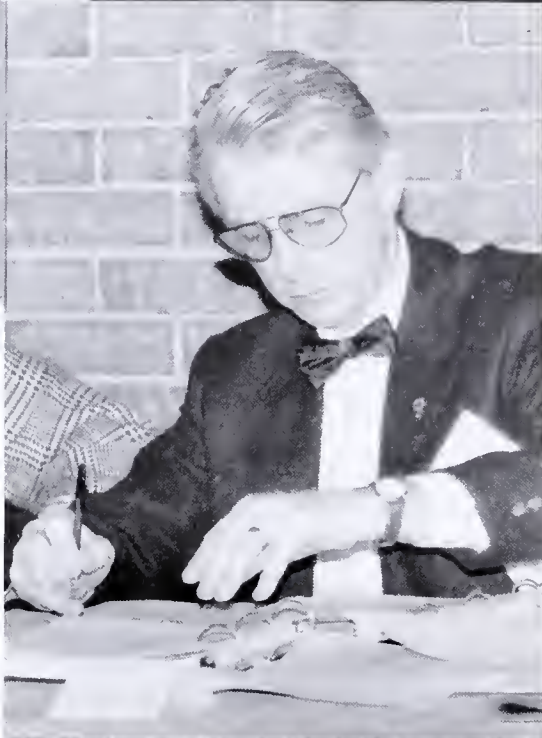
**Dr. Owen**

stealth vehicle, undetectable by conventional police radar, I was able to visit 31 of our 43 component societies, running the gamut from Accomac to Wise, and from Frederick County to Chesapeake, with the G-spot (Grundy) thrown in for good measure.

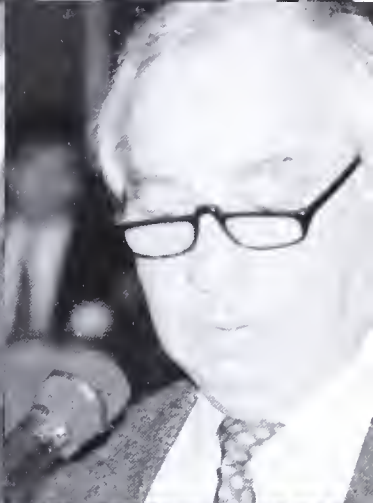
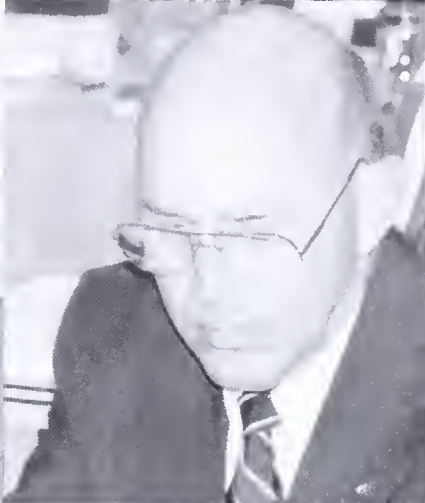
When I visited these societies, I could pretty much predict my reception. If the doctors present were young and vigorous they talked about access to health care for the indigent and the inequities of Medicare reimbursement for young physicians and rural practitioners. If they were gray-haired, they ranted and raved about Unification and the Bad Baby Bill. If they were white-haired they reminisced about what medical school was like back in the 40's and showed me pictures of their grandchildren. I concluded that the problems of the future will be solved by young physicians.

Membership is a chronic problem. This year that cross was laid on the back of Ira Godwin and Paul Galanti and they have been hard at work. Try as we may, the drop-outs still outnumber the new members. You have before you the membership re-











## “To serve our patients and honor our profession”

**I**N REMARKS opening the first session of the House of Delegates on Thursday, November 7, Dr. George E. Broman, Speaker, issued a “welcome to the 144th Annual Meeting of the Medical Society of Virginia, in the familiar and beautiful surroundings of Williamsburg. We meet to serve our patients, honor the business of our profession, respond to the challenges of our world, and to assure that our actions drive forward the cause of health above all other considerations—personal, political, or what you will. . .

“Headquarters staff and Vice-Speaker Monahan and I extend our thanks to the members of the House and the component societies for their attention to the guidelines for the submission of resolutions. Good format and promptness have greatly enhanced preparations for these sessions.”

At the second session of the House, Dr. Broman was unanimously chosen the Medical Society of Virginia's President-Elect.

recruitment program packet. I have seen this plan in action in North Carolina and it works. It all depends on you. Are you going to let a bunch of Tarheels outdo you?

You and I know that all the arguments for membership in one's local medical society, in MSV, and in AMA are true and righteous altogether, and that all the arguments against are ignorant, niggardly and insincere. So why is that we always let the nonmember seize the advantage and make us feel defensive and uncomfortable? Just remember, if that feeling comes over you, how good it's going to feel next year to stand up before this entire group and be applauded for having recruited that doctor anyway.

And I continue to press for a sequential, integrated effort to recruit medical students, keep them active as resident physician members, help them through the transition to young physicians, and then secure them as life-long members of MSV. I've charged Ira Green and the Academic Liaison Committee with the task of developing that system.

This year we have also initiated a separate recruitment drive for women physicians, and I want to

thank Barbara Mella and Carol Shapiro for taking that on, and for personally signing 1600 recruitment letters. Tomorrow we will have our first women's caucus breakfast and we all need to work to recruit them and make use of their talents.

I want to express my deep appreciation of the work of our Auxiliary. It has been my privilege to share the load with two outstanding presidents, Heidi Guerrero and Eileen Thomason. So effective have they been that I finally caught on, and started appointing auxiliaries to MSV committees. Already, they are making a difference.

It has thrice been my privilege to attend AMA meetings along with our delegation. While Virginia is not famous for introducing legislation, your delegates are much respected and admired, which explains why Dick Fields and Chris Alexander have been elected to the Councils on Constitution and Bylaws, and on Medical Service, respectively, and why Percy Wootton prevailed over two very strong contenders and was elected to the powerful Board of Trustees on his very first attempt.

The MSV committee structure is complex and comprehensive but

performance is not always dynamic. I sometimes have to tell myself that 15 or 20 doctors, from all over the Commonwealth, taking time out from busy practices on short notice, cannot be expected to sit around the table at Dover Road a couple of afternoons per year and come up with the modern equivalent of the Magna Carta. Not much is going to happen unless the president clearly articulates a charge, an agenda and some priorities to the chairman, so that the latter can work with staff to articulate them to all members. So to the extent that we have not flourished, perhaps the fault is mine. But we have made a start, and next year I'm sure things will go better.

As many of you know, we have two independent entities closely associated with the Society, the MSV Service Corporation and the MSV Foundation. After a long dormant period, both are beginning to come awake.

The MSV Service Corporation has established a number of programs to generate non-dues income for MSV. Over the past six years, the accumulated balance has grown to \$254,121. At a meeting of the Corporation on Wednesday, we voted (1) to transfer \$190,000 of Corporation funds to our general fund, in order to avoid further depletion of the reserves, and (2) to transfer another \$50,000 to the Foundation. Furthermore, as president of the Corporation, I pledge to work with Mr. Galanti next year in an effort to develop new and improved income-producing activities.

The MSV Foundation is a tax-exempt charitable foundation, headed by Dr. William Barney. Bill has studied the scope and activities of the Foundation of the North Carolina Medical Society, and is itching to make ours equally successful. At a recent meeting the Foundation voted (1) to restructure itself in order to include influential, non-physician members, (2) to mount an ambitious fund-raising effort among physicians, business leaders, civic



groups, and other potential resources, (3) to continue to develop plans to help medical school tuition, and (4) to support innovative pilot projects which will enhance health care by means of free clinics for the indigent, lowered medication costs, etc.

**N**OW FOR some specific recommendations: The Executive Committee, the Committee on Committees, and the Long-Range Planning Committee are all vital to the flexible, consistent, and progressive functioning of MSV. I recommend that the ByLaws be amended to insure that these committees be chaired, *ex officio*, by the President, President-Elect, and First Vice-President respectively and that they hold joint meetings at least twice a year. I recommend that the first joint meeting be concerned with developing a staff evaluation process and more efficient utilization of staff effort for specific committees.

We have a good structure for dealing with Medicare problems, utilizing our committees on Aging and Third-Party Payors. We have no comparable committee for Medicaid problems. I recommend that the Aging, MSVRO Oversight, and Third-Party Payor Committees be merged, and subdivided into four subcommittees responsible for Medicare, Medicaid, MSVRO, and commercial insurer interactions.

The problem of medical care for the un- or under-insured faces us at every turn. I recommend that the Emergency Medicine, Indigent Care, and Rural Health Committees be merged, retaining a triple subcommittee status but uniting to consider broader implications of the access problem.

Our Committee on Health Promotion has already made a beginning at health education in terms of the school system. I think The Medical Society of Virginia needs a permanent speakers bureau to provide grassroots education to everyone in

every community in our state, and I so recommend. It won't be a lot of fun, but if we continually try to learn as well as to teach, The Medical Society of Virginia will achieve a public respect which will serve us well in future policy decisions.

As Virginia acquires an 11th congressional district, we will need to move quickly to specify redistribution of component societies, mechanisms for selection of a new counselor, vice-counselor, nominating committee person, and VaMPAC representatives. I recommend that the Bylaws Committee begin work on this at once in order to have these details ready for approval at the interim meeting in May.

During the past year, your incoming President, Dr. Hollowell, chaired the *ad hoc* Physician Advocacy Committee, which explored our relationship with the State Board of Medicine and made a number of excellent recommendations. Because of the predictable complexity of our interactions with the Board, I believe this good work should be continued. I recommend therefore, as does the Virginia Society of Internal Medicine, that MSV create a Board of Medicine Liaison Committee, to preserve and extend our excellent collaborative efforts, and to assist in finding good people to do the heavy load of work that the Board must do.

In the latter regard, we realize that now, more than ever, the selection of nominees for appointment to the Board demands intense scrutiny and preparation. I therefore recommend that the Liaison Committee actively solicit meetings and discussions with the Old Dominion Medical Society in order to effect (1) agreement on proportionate representation of our two societies on the Board, (2) joint review and agreement on credentials and ranking of candidates for appointment to the Board, and (3) joint ratification of these agreements prior to their presentation to the Governor, in person, by the leadership of both societies.

My final recommendation is the most audacious of all. We have an annual budget now approaching \$2,000,000, plus our reserve funds, the funds in the Service Corporation, and the funds in the Foundation. We ask a busy and overworked Finance Committee, which meets twice a year to wrestle with the auditors, to propose an annual budget which is increasingly complicated and always difficult for the Council and this House to understand and to address constructively.

I'm sure all these problems won't automatically be solved by my recommendation, but here it is: I recommend that we elect a Treasurer (for a three-year term) from our physician membership and that the fiscal affairs of the Society be concentrated in his hands, as is done in the societies of our neighboring states. The Finance Committee would continue to serve as an advisory board but this would take some of the burden of budgetary concerns off the Executive Vice-President, thus enabling him to devote more time to directing the staff at work on the day-to-day activities of the Society. I trust that our distinguished guests here today may volunteer to relate to Reference Committee 3 how effectively this system works in their states. This will necessitate more bylaws changes, demonstrating again that evolution is fun.

**A**ND NOW, my friends, I've talked long enough. I conclude my year with even more hope and excitement for the future than I had last year. What I wanted to see happen then, by and large, has happened. What Jack Hollowell wants to see happen next year, with another year of cheerful assistance from you, will surely happen also. I step down, not to an easy chair, but to rejoin you of the rank and file in applauding, encouraging, and assisting in every way the next President of The Medical Society of Virginia.

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## JOHN W. HOLLOWELL:

“In the changes ahead, be either a participant or a victim.”

WITH the approach of 1992, great changes loom ahead in our system of delivering health care. When the Medical Society of Virginia's leadership visited the Virginia delegation in Washington in July, we were warned by Congressman Norman Sisisky that major reforms are coming: “If not in this Congress, certainly in the next Congress.” As health care costs approach 12% of the gross national product, there are signs that this \$110 billion is about all the market will bear. A better way of expending our health care dollars must be found. We in the Medical Society of Virginia must take a pro-active role in helping to shape these changes so that the best in our present system can be preserved. For in spite of its shortcomings, we have undoubtedly the best health care system on earth.

The role of our profession must be to ensure that the American people continue to receive the finest quality health care in the world. We must resist with all our force the efforts of those who would set up in America a plan modeled after the rationed health care system of Canada. Nor is the British system of socialized medicine acceptable. In the last eleven years, England has hired an additional 18,000 bureaucratic medical administrators. The Soviet health system, like everything else in the communist structure, is a crumbling disaster. Germany has a system that works moderately well for Germany,

but as Dr. Gail Wilensky advised at our Congressional Luncheon in Washington in May, the German system would never work in America because of this country's size, different history, and its pooling of vastly different ethnic groups with heterogeneous religions and customs.

It's one thing to identify the deficiencies in other systems and quite another to reshape our own in ways that are better. However, as AMA consultant Michael Dunn has warned, “In the changes ahead, be either a participant or a victim.”

There are several areas where the Society can participate to improve and reshape our policies for a better future:

The first is access to care. There are 37 million Americans without health insurance, and 880,000 of these are in Virginia. This is unacceptable. More must be done. Dr. Kim Buttery, cochairman of our Rural Health and Indigent Care Committee, will work in the coming year with the state and other agencies to make improvements in rural and underserved sections of the Commonwealth. Recent increases in Medicaid reimbursement will also make care more available in all parts of the state, but particularly in rural and inner-city areas. Another step in improving access to care is to revamp the insurance market. More affordable insurance policies must be devised so that small companies can afford coverage for their employees. Many frills and some benefits may have to be reduced in order to provide these packages, but the net result will be more coverage for more people.

Another way MSV members can work to improve our policies is to restore professionalism. Steps must be taken to restore the high esteem that our profession has enjoyed over all others. Former House Speaker “Tip” O’Neil told the AMA at its June meeting in Chicago that physicians are still the most respected and effective group in any American community. Those of us “within the group,” however, are aware that there has been some recent erosion of that high image. Former Chief Justice Warren Burger, addressing the AMA Leadership Conference in Florida last January, cautioned against inappropriate advertising by the profession. As he noted, advertising is constitutionally protected, but it is in the gray area of ethics. Justice Burger's advice was to “never seek the services of an attorney or a physician who finds it necessary to advertise.”

We must put down the rise of commercialism in medicine. We must resist the efforts of outside mercenaries so skilled at organizing and entrapping physicians in seductive investment packages which exploit the system.

Third, we must redirect health care resources. Knowing that 80% of Medicare funds are spent in the last six weeks of life, we must revisit the judgment that prolongs agony and delays death in a hopelessly ill patient who lies in a vegetative state being sustained by long periods of tube feeding. A loving family frequently demands that “everything possible be done.” Only the caring and compassionate physician can advise what is not possible and what is, in fact, the most humane treatment. The MSV Professional Standards Committee, can, working under AMA guidelines, study and advise concerning what is described as the “abusive use of scientific methods of preventing death in those cases that cannot live.” Guidelines must be set for excessive and unnecessary use of investigative tech-

This is Dr. Hollowell's Inaugural Address, delivered during the second session of the House of Delegates on November 9, 1991, after his installation as MSV President.



niques where the cost is high and the expected benefits low. We cannot continue supplying infinite treatment with finite resources.

Another problem is pharmaceutical costs. The inflationary trends in pharmaceutical houses must be stemmed. Over the past decade prescription drugs have risen up to 300% in price, compared with a 28% increase in general inflation. Companies should be expected to make a profit and realize a return on research investments, but there is no excuse for one Feldene<sup>®</sup> capsule costing \$1.91—nearly three times the price charged when this heavily prescribed drug was introduced ten years ago.

The Medical Society of Virginia should explore the concept of devising basic insurance coverage for those who cannot afford the deluxe package. Medications have come to be the most inflationary component in insurance coverage. If a package were devised in which medication would be supplied only in the hospital setting, this might remove the "free drug" perception and return some cost restraints to the pharmaceutical community. The offer of a free Caribbean vacation by pharmaceutical houses in exchange for prescribing their products is repugnant. Fortunately, this practice has been forbidden both by federal regulation and AMA ethical guidelines.

We must also remain aggressive in encouraging malpractice reforms. Having had limited success on the state level to sustain significant changes in costly malpractice litigation, we *must* support the AMA and encourage our congressional delegation to support the Bush Administration's efforts to bring about changes at the federal level.

More work we can do at the state level concerns regulatory boards. In keeping with the national call for strengthening state Boards of Health, the Society will establish this year a Health Regulatory Board Liaison Committee to further the



**Assembled in the lobby of the Williamsburg Lodge after their election at the Annual Meeting are the Medical Society of Virginia's officers for 1991-92. Standing, from left to right, are the new President, Dr. John W. Hollowell, Portsmouth; Dr. George E. Broman, Culpeper, President-Elect; Dr. James A. Shield, Jr., Richmond, First Vice-President; Dr. William A. Hazel, Jr., Herndon, Vice-Speaker, and Dr. Lawrence K. Monahan, Roanoke, Speaker of the House. Seated in front are Dr. Randolph J. Gould, Third Vice-President (left), and Dr. Maurice M. Miller, Second Vice-President, both of Norfolk. A biography and formal portrait of Dr. Hollowell appears on page 52, and a list of the entire slate elected for the coming year appears on page 55.**

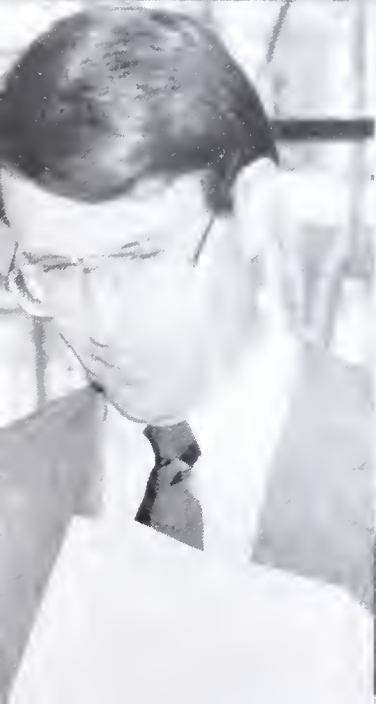
work of the Physician Advocacy Committee.

Another issue close to my heart, and one that we must address is changes in medical education. Medical schools should include in their curricula instructions in the economics of medical practice, teaching among other things the appropriate utilization of high-tech facilities available today. This concept has been enthusiastically endorsed by the director of the Department of

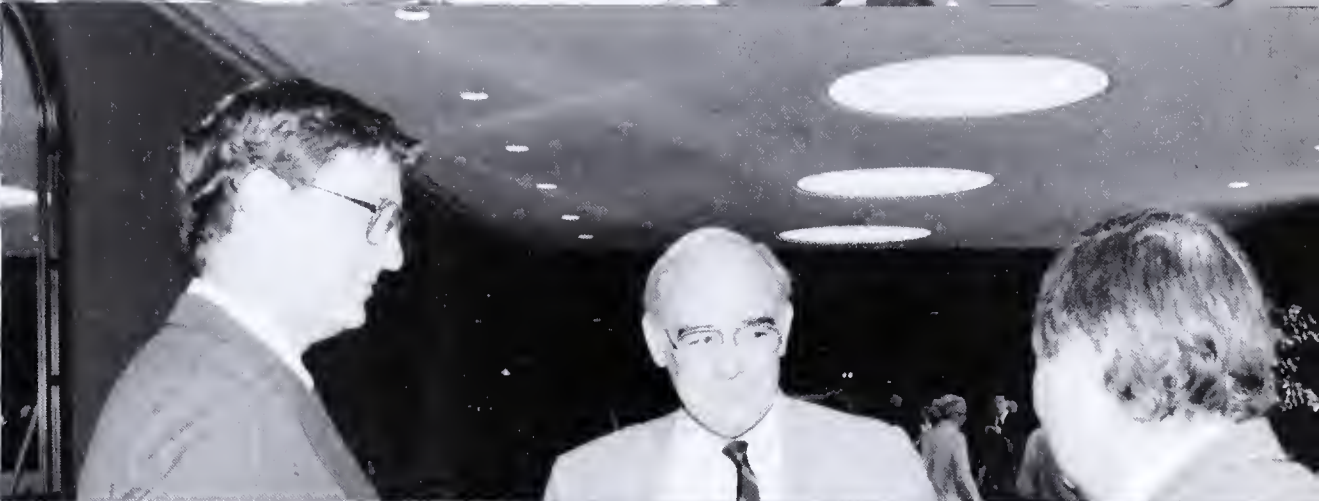
Medical Assistance Services as an approach long past due. I have called on the deans of the three medical schools in Virginia concerning this issue, and the idea has been well received. The Academic Liaison Committee will follow up on this.

Medicine is constantly changing—not only medical education, but also legislation governing the established physician. In 1987, because of the strong support expressed by Virginia physicians and through the diligent











efforts of MSV leadership, lobbyists and lawyers, the Injured Infants Act passed in Richmond. And we're still working on it. This year, we have already begun working with the State Insurance Commissioner to try to put a moratorium on the \$250 annual assessment against all physicians. We have a plan to achieve this as soon as there is actuarial proof that the \$40 million now in the fund will support the plan for the foreseeable future. Virginia doctors are proving for the fifth year that they will go that extra mile to help the system. Enough is enough.

Finally, and perhaps most importantly, all of these changes require the energies of all the doctors in Virginia. We cannot function effectively when MSV membership represents only 46% of the doctors practicing in Virginia.

Our Membership Committee, under the leadership of Dr. Ira Godwin and the vice-councilors, and using the considerable skills of Jim Moore, Paul Galanti, Jonathan Perry, and Wanda Schwarzmenn, will be mounting a recruitment drive aimed at substantially increasing our membership toward a goal of 58% in 1992, thereby providing more talent, energy and resources to accomplish the tasks ahead. We will also give consideration to establishing an MSV Foreign Graduate Section and call on all of you as leaders in your component societies to assist us.

The Medical Society of Virginia has a long and proud history of responsible activism in behalf of quality health care for the people of the Commonwealth and the nation. Working together we can and must continue to take a positive leadership role to establish policies that will improve and maintain the dignity of what must be the most respected profession of all.

Thank you for placing confidence in me by electing me to be your President. I pledge to you my best effort to justify that confidence.

## LARRY J. SABATO:

### "Can George Bush be beaten? Yes! Are term limits a good idea? No!"

**T**HE University of Virginia's famous inside trader in political lore, Larry Sabato, came to the Annual Meeting in Williamsburg with some hot tips for VaMPAC members at their yearly banquet. Speaking off the cuff throughout, the professor/author/media star free-wheeled through a short speech and a long question and answer session with some forthright predictions peppered with inside stuff on well-known names and races. The audience enjoyed him hugely. Here is a sampling.

On the November 1991 elections. "Clearly these were an unusual set of elections. You can tell they were unusual when an outstanding state senator like Clancy Holland, who has a distinguished record and was running against an unknown of no significant accomplishments whatsoever, scraped through to victory with only 53%.

"The truth is that though there were many reasons why this happened, there was one central reason, and that was a tide of anti-Doug Wilder sentiment. Doug Wilder is the most unpopular governor of Virginia in modern times, certainly the most unpopular one since polls have been taken. There has never been a governor who has registered below 50% in any single public opinion poll, but Doug Wilder has been mea-

suring, depending on the region of Virginia or the statewide survey, anywhere from the teens to 30% popularity.

"Just to give you a measure of how well the Republicans did—I had to go back to several history texts to find this out, it's kind of obscure—Virginia's Republicans now have more state legislators than they have had since 1881, a century ago. I doubt seriously, however, that the nation will pay much attention. It has been buried in the avalanche of information about other significant races, like the one in Pennsylvania, where Harris Wofford truly did send George Bush a case study on how not to run his reelection campaign. To blow a 44-point lead and lose the election by 10 points, which is a 54% shift in a campaign only three months long, is very difficult to do, but Dick Thornburgh managed to do it, and the Democrats feel for the first time they have a chance to beat George Bush.

"Can George Bush be beaten? Of course he can! Because any team can beat any other team on any given day in the right set of circumstances. That's as true in politics as it is in sports.

"But pay attention to three macro forces that always have and always will determine presidential elections. The first is the economy, and that's George Bush's Achilles heel potentially. If the economy slips back and we have a double-digit recession, or if the economy is stagnated, then even a little-known Democrat has a chance. The second macro force is war or peace, and that obviously at this point favors George Bush very substantially because of the good

Larry Sabato is professor of government and foreign affairs at his alma mater, the University of Virginia (1974). As a Rhodes scholar he earned his PhD in politics at Queen's College, Oxford University. Address correspondence to him at 232 Cabell Hall, University of Virginia, Charlottesville VA 22901.



ending to the Gulf War. And the third macro force is scandal. So far we don't have a scandal involving President Bush. And a scandal has to touch a President directly. Air Sununu won't do, it's just not enough.

"Finally, I think one thing George Bush has achieved which will help him considerably is that he has developed a high comfortability level with the American public. The voters basically like him even if they disagree with him, and they like his family. They like most of the values that he seems to project.

"So on the whole, while you have to allow for a very real possibility that the Democrats could pull a surprise, you'd still have to put your money on George Bush."

**O**PENING the question and answer period, Sabato fielded a request for a comment on the impact of the election of Tom Moss as House Speaker.

"Tom Moss has waited a long time and worked very hard to be Speaker, and he's not going to want to give it up any time soon, so I expect that Democratic party efforts to reelect their incumbents and to save open seats will intensify in 1993. Obviously, we're at the point now where every election presents the possibility of Republican take-over of one or both houses of the General Assembly, which I'm not advocating, but I will say that two-party competition is long overdue in this state, and it is a very good thing, it produces good government."

Will Chuck Robb run for reelection in 1994? One of the physicians in the audience asked.

"Robb can choose not to run again, and that might be the wisest thing for him and certainly for his family, given the kind of campaign that he would have to undergo and the kind of information that would be made public, and I do expect and believe that more information about his activities will come out and it



**Dr. H. Alan Bigley, Jr., VaMPAC chairman (left); and Larry Sabato neckerchiefed for the lobster banquet**

should.

"Or he can run for reelection and by no means be assured of defeat. Lots of scoundrels and rascals have been reelected to the United States Senate, and the Republicans can end up nominating a weak candidate and Robb can win by default, or maybe no Democrat will challenge him for the nomination."

Another questioner wanted to know Sabato's position on term limits.

"I am strongly opposed to term limits, and for the same reason that I'm opposed to all these silly restrictions on your constitutional rights in participating in political action committees.

"Term limits sound good because you get a rotation in office and get rid of whatever incumbent you don't like. But what are the unintended consequences? You end up strengthening other actors in the political system. Power abhors a vacuum, so when you reduce the power of one institution, the Congress, you increase the power of other institutions and actors, so by term limits you're going to reduce the institutional memory, the power, of Con-

gress, and who are you going to strengthen? The bureaucrats! There are no term limits on bureaucrats, and they will end up having the institutional memory you're denying Congress. There won't be any term limits on congressional staffers, they float from member to member and already have too much power, too much influence on the legislation that's enacted. If you think elected officials are arrogant sometimes, try dealing with some of the staffers, they'll show you what the arrogance of power is all about. And you'll strengthen lobbyists because they'll also have the institutional memory denied the Congress.

"The solution to bad incumbents is to do what the Republican party did in this state, and that is nominate good candidates and contest the elections vigorously. We already have term limits. They're called elections."

**T**HE next questioner praised Professor Sabato's latest book, *Feeding Frenzy: How Attack Journalism Has Transformed American Politics* (The Free Press/Macmillan), a lively, anecdotal study

## “A pattern of influencing health legislation”

Addressing the House of Delegates during its first session, the Medical Society of Virginia Auxiliary's president, Mrs. Eileen Thomason, described the MSVA's increasing involvement in the Society's legislative efforts.

“We have joined the Society in the Virginia Prevention and Advocacy Network, a group of organizations concerned with health policy legislation,” she said. “We are networking with the Virginia Department of Education on comprehensive health education, and are helping the Department of Health with a statewide health needs survey. Instead of sponsoring a formal Legislative Day at the Capitol in Richmond, we are going to hold a legislative skills workshop.

“So there is a pattern of influencing and implementing health policy legislation. . . . That is why we in the Auxiliary are very interested in what actions you take in this session. They will have a direct impact on which directions we take.”

of the pathology of media bloodsport published in August 1991 before the Clarence Thomas hearings, and asked Sabato to comment on the media's feeding frenzy over those hearings.

“Well, it was just fundamentally depressing to me for lots of reasons but most particularly because that sort of spectacle has become the norm in politics. It's not the politics of issues or of substance, it's the politics of scandal and sleaze and infamous character. That's how we're conducting politics and that's how we're eliminating people from public life. We've got to stop focusing all of our attention on private foibles and transgressions and put the spotlight on what really matters, which is the policy and public issues of the day. It was a horrible spectacle and it really tells you the depths to which we've descended.”

“Clancy, you had a question,” the visiting professor called out. Dr. Holland responded by asking to hear Sabato's position on electing school boards.

“Electing school boards is one of the worst ideas in many years. Most voters don't pay enough attention to

politics to cast an informed vote even with a short ballot and at the highest level. At the lower levels and particularly for something like school board elections, I can guarantee you that it's going to be a disaster if it happens. You're going to have lots of special interest groups controlling these elections because they are going to be very low-turnout, and you'll have every kook group from whatever wing, left or right, out there working to elect their kook candidates supporting their kook platforms. You will have campaign financing channeled into the races, and I predict that within three or four election cycles those school board seats will cost on average 30, 40, 50 thousand dollars in the urban markets. You will price out of the market good, responsible citizens who are willing to serve and make a contribution when they are appointed but are unwilling to spend so much time campaigning and raising money to be elected to a part-time position, it's just asking too much of them. There will always be kooks who have nothing else to do willing to do that. Nor will it do anything to improve the quality of our schools;

**Detach this section  
for your reference**

rather, I would be willing to bet it will reduce their quality.”

“How about giving school boards the authority to tax?” was the next question.

“That's even worse. If you think your taxes are high now, try school boards that have taxing authority!”

Another PAC member wanted Sabato to comment on recent efforts in the U.S. Senate to abolish political action committees.

“I think it's sad that a President of the United States and many members of Congress, who have sworn in their oaths to uphold the Constitution of the United States, would openly and freely advocate something that is clearly, manifestly unconstitutional. To abolish political action committees is a direct violation of your first amendment rights, not only your right to free speech but also your right to free political association. I know not a single respectable constitutional authority who disagrees with that point of view. When the Senate passed its abolition on PACs, it included a backup clause that said, in effect, we concede that this will be thrown out by the courts, so when that happens, we reduce the maximum contribution from \$5,000 to \$1,000. I think it's pitiful when elected officials openly violate their oaths to pass something merely because it panders to a popular conception of a completely legitimate and healthy political mechanism, which is what a political action committee is.

“I don't think PACs will ever be abolished because the courts are there, fortunately, to guarantee our constitutional rights.” ■



# House of Delegates Actions on Resolutions

Here are the results of the 117 resolutions and recommendations considered by the Medical Society of Virginia's House of Delegates at the 144th annual meeting November 6-9 in Williamsburg. The session was conducted by George E. Broman, MD, Speaker and Lawrence K. Monahan, MD, Vice-Speaker. For a copy of the resolutions/recommendations in their entirety, call MSV headquarters, 804-353-2721.

Resolution/Recommendation, <i>Sponsor</i> , Description	Adopted	Amended, Adopted	Referred to Council	Not Adopted
<b>ACCESS/PRIMARY CARE</b>				
<b>Resolution AA: Statewide Volunteer Medical Assistance Programs</b> ( <i>6th Councilor District</i> ). Medical Society of Virginia to explore feasibility of voluntary Medicare assignment program.			✓	
<b>Resolution E: Hospital Insurance Company Contracts</b> ( <i>10th Councilor District</i> ). Medical Society of Virginia to study impact of hospital/carrier contracts on patient's freedom of hospital choice.			✓	
<b>Resolution CC: Health Access America Program</b> ( <i>Fairfax County Medical Society</i> ). Continued MSV support for implementation of the program.		✓✓		
<b>Resolution UU: Health Promotion/Disease Prevention</b> ( <i>Virginia Academy of Family Physicians</i> ). Medical Society of Virginia to encourage insurance coverage for screening tests/medical exams.			✓	
<b>Recommendations 1-12, Report of the Rural Health Committee, and Report of Council, Item 12.</b> Medical Society of Virginia to support equal rural/urban reimbursement; more rural medical scholarships; more tort reform; legislation against antitrust, Data Bank, and PRO harassment; local credit sources for new practices; more rural health participation at medical schools; more medical students from rural areas; higher Medicaid/Medicare reimbursement; AMA position on RBRVS rural/urban inequities; protection for solo practitioners from carrier/peer review prejudice; medical transport system; increased physician participation in medical examiner system.	✓			
<b>Resolution VV: Home Health Agencies</b> ( <i>Virginia Academy of Family Physicians</i> ). Medical Society of Virginia to work for physician reimbursement schedule for home health care.	✓			
<b>Resolution C: Access to Medical Care</b> ( <i>Emergency Medicine Committee and American College of Emergency Physicians, Virginia Chapter</i> ). Medical Society of Virginia to determine actual contribution of private physicians to medical access and formulate program to inform public of findings.	✓			
<b>Resolution SS: Incentives to Increase Availability of Health Services for the Poor</b> ( <i>6th Councilor District</i> ). Medical Society of Virginia to explore ways to mitigate malpractice risk of retired physicians who volunteer to serve the needy, plus possibility for state funds for liability coverage.	✓			
<b>COMMUNICATIONS</b>				
<b>Resolution T: Computer Coding of New Medical Services</b> ( <i>10th Councilor District</i> ). Ask AMA to develop guidelines for dealing with carriers in absence of service codes.				X
<b>Resolution EE: CPT Code Allowances</b> ( <i>Norfolk Academy of Medicine</i> ). Medical Society of Virginia to seek state law requiring health insurance companies to make known to the insured the allowances for care, by CPT code, when requested.		✓✓		
<b>Resolution PP: Health Insurance Remittance Vouchers</b> ( <i>J. Latane Ware, MD</i> ). Medical Society of Virginia to promote uniform usage of codes/units by all carriers doing business in Virginia.		✓✓		
<b>Resolution FF: The Term "Health Care Providers"</b> ( <i>Charles Beorn, MD</i> ). Medical Society of Virginia to ask insurance companies to refer to doctors as "physicians."			✓	
<b>Resolution TT: Governmental Statements Regarding Delivery and Cost of Medical Care</b> ( <i>10th Councilor District</i> ). Ask AMA to scrutinize/rebut unsupported statements/conclusions by public officials.		✓✓		

Resolution/Recommendation, <i>Sponsor</i> , Description	Adopted	Amended, Adopted	Referred to Council	Not Adopted
<b>Resolution X: Reimbursement for Workers Compensation Injuries</b> ( <i>10th Councilor District</i> ). Medical Society of Virginia 1) to investigate letters to patients from carriers/others stating fees are above prevailing rate or are unnecessary and 2) to aid physicians in rebutting such allegations.		✓✓		
<b>ETHICS</b>				
<b>Recommendations 1-4, Report of the Biomedical Ethics Committee.</b> Medical Society of Virginia does not support refusal to treat solely because patient has AIDS/HIV, does support 1) physician's right to refuse futile treatment; 2) arbitration by hospital ethics committee of recalcitrant conflicts about terminal care; and 3) right of physician to withdraw from conflicted case.	✓			
<b>FEDERAL LEGISLATION</b>				
<b>Resolution NN: Freedom of Contract</b> ( <i>10th Councilor District</i> ). Ask AMA to review rights of patients to seek medical care independent of Medicare regulation.				X
<b>Resolution V: Counseling for Abortion Services</b> ( <i>Virginia Obstetrical and Gynecological Society</i> ). Medical Society of Virginia to oppose Title X regulation prohibiting abortion counseling/referral/physician-patient discussion.	✓			
<b>Resolution JJ: RBRVS as Tool to Reduce Budget</b> ( <i>Virginia Academy of Family Physicians</i> ) and <b>Report of Council, Item 11.</b> Medical Society of Virginia to oppose any efforts to use RBRVS as budget reduction tool or to use behavioral offset concept in setting fees.	✓			
<b>HIV/AIDS</b>				
<b>Recommendation 1, Report of the Committee of AIDS.</b> Endorse CDC and AMA in developing guidelines for testing health care workers with HIV infection.		✓✓		
<b>Resolution N: Newborn Screening for HIV Infection.</b> ( <i>Virginia Chapter, American Academy of Pediatrics, and Virginia Pediatric Society</i> ). Medical Society of Virginia to recommend routine screenings when HIV infection rate is 1/1000 deliveries or above.				X
<b>INTERNAL AFFAIRS</b>				
<b>Recommendation, Finance Committee and Council.</b> 1991-92 Budget, as shown elsewhere in this section.	✓			
<b>Recommendation, Reference Committee 3.</b> Honorary membership for John A. Owen, Jr., MD, MSV President, 1990-91.	✓			
<b>Recommendations 1 and 2, Membership Committee.</b> 1) That the Medical Society of Virginia have a young physicians category. 2) That Council consider revising the Articles of Incorporation to include out-of-state resident physicians with Virginia licenses as associate members.		✓✓		
<b>Recommendation, Report of Council, Item 14.</b> That there be an interim session of the House of Delegates in 1992 and 1993 to consider legislative affairs.				X
<b>Recommendation GG, Cessation of Certification of CME Programs</b> ( <i>Harry C. Kuykendall, MD</i> ). Medical Society of Virginia to cease CME requirements.				X
<b>Recommendations, Report of the Bylaws Committee.</b>				
Item 1. Change bylaws so that for husband/wife physicians, MSV dues for the second spouse are 50% of regular rate.				X
Items 1-3, 4, 6. Approve recommended dues change for husband/wife members (above) on two-year trial basis. Revise the Articles of Incorporation to establish cardiology as a specialty section. Constitute Biomedical Ethics Committee at five members or more. Add to Article IXA section outlining Grievance Committee procedures. Amend Article III, Section 10, by adding guidelines for new specialty sections.	✓			
<b>Recommendation, Reports of the Bylaws Committee, Item 6, and the Committee on Committees, Item 2.</b> Change name of Committee on Ethics to "Professional Standards Committee."		✓✓		
<b>Recommendation, Presidential Address</b> ( <i>Dr. Owen</i> ). Creation of the Office of MSV Treasurer.			✓	



Resolution/Recommendation, <i>Sponsor</i> , Description	Adopted	Amended, Adopted	Referred to Council	Not Adopted
<b>Recommendation, Presidential Address (Dr. Owen).</b> Establishment of a permanent MSV Speakers Bureau.	✓			
<b>Recommendations, Report of the Committee on Committees, Items 1 and 3.</b> Institute computer system to track MSV terms of office, meeting attendance, specialty distribution. Change Therapeutics and Devices Committee to ad hoc status.	✓			
<b>Recommendation 1, Report of the Indigent Care Committee.</b> Combine Indigent Care and Rural Health Committees.	✓			
<b>Recommendations 1-7, Report of the Long-Range Planning Committee.</b> MSV goals and objectives: promote quality health care; communicate with public more effectively; attract/retain members; strengthen component societies; advocate physician interests; maintain effective MSV management; provide responsive commercial services/educational programs.	✓			
<b>MEDICAL EDUCATION</b>				
<b>Resolution WW, The International Model World Health Organization (Gordon McLennan, Medical College of Virginia student).</b> Medical Society of Virginia to support/promote TIMWHO's efforts to educate medical students/physicians about international health issues.	✓			
<b>PRESCRIBING/DISPENSING</b>				
<b>Resolution KK: Expiration Dates for Prescription Drugs (Portsmouth Academy of Medicine ) and Resolution RR: Drug Expiration Date (Southside Virginia Medical Society).</b> Medical Society of Virginia to support law requiring expiration dates on all prescription drug labels.	✓			
<b>Resolution A: Insurance Coverage for Antineoplastic Drugs (Mario Kuperminc, MD, and James T. May III, MD).</b> Medical Society of Virginia 1) to oppose denial of coverage because use is not FDA-approved, and 2) to develop guidelines for determining propriety of investigational and experimental designations for drugs/devices/procedures.		✓✓		
<b>Recommendations 1 and 2, Report of the Therapeutics and Devices Committee.</b> Medical Society of Virginia to 1) work with state insurance officials and carriers in defining "therapeutic" and "investigational" and 2) appoint delegate to State Pharmacopeial Convention 1990-95.		✓✓		
<b>Resolution II: RU-486 (10th Councilor District).</b> Medical Society of Virginia to ask General Assembly to approve RU-486 for use in Virginia on experimental basis.				X
<b>PUBLIC HEALTH</b>				
<b>Resolution P: Virginia Poison Network (Emergency Medicine Committee and American College of Emergency Physicians, Virginia Chapter).</b> Medical Society of Virginia to support establishment and funding of Virginia Poison Information Network.	✓			
<b>REVIEW/DISCIPLINE</b>				
<b>Recommendations 1-5, Report of the Physician Advocacy Committee.</b> Medical Society of Virginia to 1) designate a staff member to handle complaints; 2) improve Medicaid/Medicare relationships; 3) develop brochure on physician advocacy, disciplinary processes, legal help; 4) work up list of Virginia attorneys with medical expertise; 5) promote brochure through MSV newsletter.	✓			
<b>Recommendations, Supplemental Report of the Physician Advocacy Committee.</b> <b>Items 1-3, 5, 7.</b> Medical Society of Virginia to 1) support legislation authorizing Board of Medicine hearings with 8-member panel (5 or more to be MDs/DOs) and utilization of prior Board members on informal conference committees; 2) encourage expert medical advice volunteers for disciplinary cases; 3) study feasibility of license renewal fee surcharge to help defray cost of MSV Impaired Physicians' Program; and to commend Dr. Read McGehee for his Board leadership.		✓✓		
<b>Items 4 and 6.</b> Medical Society of Virginia to continue to monitor Board of Medicine performance and appoint committee to make 5-year status report and to express its strong concern that Dr. Read McGehee was not reappointed to the Board.				X
<b>Resolution H: Liaison Committee With the Board of Medicine (Virginia Society of Internal Medicine).</b> Medical Society of Virginia to preserve/extend existing collaborative efforts with Board, help physicians in interactions with Board, and ensure use of careful and constructive mechanism to cultivate Board nominees.		✓✓		

Resolution/Recommendation, Sponsor, Description	Adopted	Amended, Adopted	Referred to Council	Not Adopted
<b>Resolution K: School Nurse Program</b> ( <i>Virginia Chapter, American Academy of Pediatrics, and Virginia Pediatric Society</i> ). Medical Society of Virginia to support legislation creating school nurse program for every school division.				X
<b>Resolution W: Support of Departments of Family Practice</b> ( <i>Virginia Academy of Family Physicians</i> ). Medical Society of Virginia to work for legislation to secure appropriate funding for departments of family practice.	✓			
<b>Resolution HH: Supply of Rural Physicians</b> ( <i>Virginia Academy of Family Physicians</i> ). Medical Society of Virginia to encourage medical schools to require 4-week community primary care rotation prior to 4th year, if possible.		✓✓		
<b>Resolution M: Children, a Priority in Access to Care</b> ( <i>Virginia Chapter, American Academy of Pediatrics; Virginia Pediatric Society; and Virginia Academy of Family Physicians</i> ). Support by Medical Society of Virginia for Task Force on Child Health's recommendation that children be given priority in increasing access.	✓			

## Medical Society of Virginia 1991-1992 Operating Budget

Salaries	\$803,000	Editor, VA Medical Qtrly	2,400	Virginia Health Council	1,000
Stationery & Supplies	20,000	Legal-General Assembly	20,000	Hospital Residents Section	1,500
Office Equip Repairs & Replace	6,000	Legal-MSV Committees	20,000	Other Special Appropriations	24,100
Building Maint Repairs & Impr.	41,000	Legal-Other	15,000	Insurance Premiums	20,000
Telephone	17,000	Legislative Program	58,000	MSV Newsletter	32,000
Postage	26,000	Walter Reed Contribution	1,000	Employee Retirement Fund	196,000
Annual Meeting	55,000	MSV Auxiliary	15,000	Employee BC/BS, life & disable	66,000
Council & Committee	34,000	Membership Dues, Affiliations	1,400	Payroll Taxes	55,000
Delegates to AMA	58,000	Special AMA ERF	1,000	CME Program	22,000
AMA Campaigns	10,000	Scholarships - MCV	1,000	Fed Legislative Consulting	80,400
Staff Travel, AMA	7,000	Scholarships - UVA	1,000	Insurance Actuary	8,000
President's Expense	14,000	Scholarships - EVMS	1,000	PHEC	24,000
Presidential Allowance	20,000	Rural Health	1,000	Med. Director PHEC	40,000
President-Elect Expense	3,000	Student Medical Society - MCV	4,500	Miscellaneous	8,400
Staff Travel MSV	7,000	Student Medical Society - UVA	4,500	Computer Ops & Maintenance	10,000
VA Medical Qtrly Expenses	55,000	Student Medical Society - EVMS	4,500	Audit & Accounting	20,000
				<b>Total Expenses</b>	<b>\$1,935,700</b>

### Reference Committee One: Education, Interprofessional Relations and Federal Legislation

Norman R. Edwards, MD, Newport News,  
*Chairman*  
John Brooks, Jr., MD, Norfolk  
Warren W. Koontz, Jr., MD, Richmond  
Joseph L. Crosier, MD, Petersburg  
James E. Nevin, MD, Danville  
Richard T. Edwards, MD, Roanoke  
Margaret E. Toxopeus, MD, Winchester  
James W. Preuss, MD, Alexandria  
John W. Knarr, MD, Pulaski  
Lawrence A. Gaydos, MD, Annandale

### Reference Committee Two: Legislation and Regulation

Lawrence E. Blanchard III, MD, Richmond,  
*Chairman*  
Norman Tingle, Jr., MD, Lively  
Maurice M. Miller, MD, Norfolk  
Gerald Weitzman, MD, Portsmouth  
G. Samuel Hurt, MD, Martinsville  
William E. Painter, MD, Lynchburg  
Norris A. Royston, MD, Marshall  
F. Jay Pepper, MD, Alexandria  
Joseph H. Early, Jr., MD, Hillsville  
William A. Hazel, Jr., MD, Herndon

### Reference Committee Three: Internal Affairs

Ray A. Moore, Jr., MD, Farmville,  
*Chairman*  
Boyd M. Clements, MD, Gloucester  
Wayne W. Ferguson, MD, Virginia Beach  
Hazle S. Konerding, MD, Richmond  
Charles C. Freed, Jr., MD, Danville  
Ferderrick L. Fox, MD, Harrisonburg  
Phillip B. Fuller, MD, Fredericksburg  
Charles J. Gueriera, MD, Manassas  
Joshua P. Sutherland, Sr., MD, Grundy  
Thomas M. Fulcher, MD, Falls Church





Resolution/Recommendation, Sponsor, Description	Adopted	Amended, Adopted	Referred to Council	Not Adopted
<b>Resolution D: Appointments to Virginia Board of Medicine</b> ( <i>Danville-Pittsylvania Academy of Medicine</i> ). Medical Society of Virginia to express deep concern over politicalization of Board, urge appointments to Board without political considerations, continue to submit names of candidates for appointment, convey this resolution to the Governor.				X
<b>Recommendation, Presidential Address</b> ( <i>Dr. Owen</i> ). That the Medical Society of Virginia create a Board of Medicine Liaison Committee.				X
<b>Recommendation, Report of Fees/Peer Review Committee.</b> That the Medical Society of Virginia and the AMA seek amendments to state/federal statutes freeing review of quality of care and physicians' fees from jeopardy/challenge by Justice Department or Federal Trade Commission.		✓✓		
<b>STATE LEGISLATION</b>				
<b>Recommendation 1 and 2, Report of the Certificate of Public Need Committee.</b> Medical Society of Virginia to rescind previous positions, support deregulation of COPN, and encourage Health Department to devise more appropriate system.		✓✓		
<b>Resolution I: Certificate of Need for Obstetrics and Neonatal Intensive Care Units</b> ( <i>Virginia Chapter, American Academy of Pediatrics, and Virginia Pediatric Society</i> ) and <b>Resolution MM, Certificate of Need -- Obstetrics and Neonatal Intensive Care Centers</b> ( <i>Virginia Obstetrical and Gynecological Society</i> ). Medical Society of Virginia to support legislation to re-regulate OB and neonatal ICUs under COPN program.				X
<b>Recommendation, State Legislative Committee; and Report of Council, Item 8.</b> Medical Society of Virginia to support legislation improving insurance access for low-income workers/small businesses and to oppose legislation transferring regulation of therapeutic drugs by optometrists to Board of Optometry.	✓			
<b>Recommendation, State Legislative Committee, Report of Council, Item 8; and Supplementary Report of Council.</b> Medical Society of Virginia to 1) oppose authorizing limited prescriptive authority for physician assistants unless subject to same limitations/conditions as nurse practitioners; 2) oppose Secretary of Health and Human Resources' efforts to reduce the educational requirements for State Commissioner; 3) request the Society be consulted when selecting new Commissioner; 4) oppose legislation to increase, stack or repeal medical malpractice cap; 5) seek alternative to cap for cases involving large expenses.		✓✓		
<b>Resolution B: Motor Vehicle Safety and Blood Alcohol Level</b> ( <i>Virginia Chapter, American Academy of Pediatrics, and Virginia Pediatric Society</i> ). Medical Society of Virginia to support changing Virginia Code as follows: 1) presumption of alcohol content of blood to be set at 0.05%; 2) first DUI conviction to mandate one year non-driving (unless restricted/provisional license is issued) and Virginia Alcohol Safety Action Program probation; 3) require second offenders to participate in 30-day alcoholism treatment; 4) 6-month jail sentence for third conviction within two years. Also, Medical Society of Virginia to urge local law enforcement to use sobriety/license checkpoints.			✓	
<b>Resolution F: Need for Mandatory Reporting to Remove Barrier to Reports to the Memory Disorder Registry</b> ( <i>John R. Taylor, MD</i> ). Medical Society of Virginia to support mandatory reporting to the Registry by health care workers, care givers.			✓	
<b>Resolution S: Suspension of Fees for Neurologically Injured Infant Act</b> ( <i>Virginia Academy of Family Physicians</i> ), Item 1. Medical Society of Virginia to ask General Assembly to impose moratorium on \$250-year assessment when fund becomes actuarially sound. Items 2 and 3. Medical Society of Virginia to ask General Assembly to suspend \$5,000-year assessment for obstetrics and to allow coverage by the Act for all physicians practicing OB when fund becomes actuarially sound.		✓✓		X
<b>Resolution XX: \$250 Assessment for Injured Infant Act</b> ( <i>Newport News Medical Society</i> ). Medical Society to work for repeal of mandatory assessment.				X
<b>Resolution G: Utilization of Injured Infant Fund</b> ( <i>Southside Virginia Medical Society</i> ). Medical Society of Virginia to oppose 1) use of Injured Infant Act funds for other purposes and 2) establishment of other, similar funds.				X

Resolution/Recommendation, (Sponsor), Description	Adopted	Amended, Adopted	Referred to Council	Not Adopted
<b>Resolution BB: Medical Necessity</b> ( <i>Psychiatric Society of Virginia</i> ). Medical Society of Virginia to seek 1) licensure to practice medicine in Virginia (and board certification in the appropriate specialty, when applicable) of all persons who render "medical necessity" opinions and issue preauthorization denials, and 2) pursue "hold-harmless" legislation on behalf of physicians who, after exhausting appeals procedures, adhere to denial determination.		✓✓		
<b>Resolution L: Preauthorization Credentials</b> ( <i>Norfolk Academy of Medicine</i> ). Medical Society of Virginia to seek legislation mandating issuance of all preauthorization denials by physicians licensed in Virginia and board certified when indicated.				X
<b>Resolution O: Trauma Care Reimbursement</b> ( <i>Emergency Medicine Committee and American College of Emergency Physicians, Virginia Chapter</i> ). Medical Society of Virginia to support Virginia Senate's study of trauma care reimbursement.		✓✓		
<b>Resolution Q: Discovery of Medical Records -- Reimbursement for Cost</b> ( <i>Fairfax County Medical Society</i> ). Medical Society of Virginia to petition the General Assembly to repeal maximum charge of 50 cents per page for medical records.				X
<b>Resolution R: Do Not Resuscitate Orders</b> ( <i>Emergency Medicine Committee and American College of Emergency Physicians, Virginia Chapter</i> ). Medical Society of Virginia to seek legislation authorizing emergency services personnel to carry out DNR orders executed by patient/physician in prehospital setting.	✓			
<b>Resolution DD, Honoring Advance Directives by Emergency Medical Personnel</b> ( <i>Read F. McGehee, Jr., MD</i> ). Medical Society of Virginia to encourage legislation allowing emergency personnel to honor "advance directives."				X
<b>Resolution OO: Extending Do Not Resuscitate Rights to Homebound Patients and Others Cared for By Outside Health Care Facilities.</b> ( <i>Charles F. Beorn, MD</i> ). Medical Society of Virginia to encourage state legislation extending DNR rights to homebound patients.				X
<b>Resolution Y: Practice of Physical Therapy and Physician Referral</b> ( <i>Roanoke Academy of Medicine</i> ). Medical Society of Virginia to oppose deletion of current law restricting physical therapist to practice only on referral of licensed physician.				X
<b>Resolution LL: Direct Access by Physical Therapists and Physician Assistants</b> ( <i>Southside Virginia Medical Society</i> ). Medical Society of Virginia to continue to oppose direct access to patients of physical therapists and physician assistants.				X
<b>Resolution AAA: Expansion of Indoor Clean Air Law</b> ( <i>J. Shelton Horsley III, MD</i> ). Medical Society of Virginia to support changing law to significantly restrict or prohibit smoking in all public places and to maintain employer's right to limit/prohibit smoking in workplace.		✓✓		
<b>Resolution BBB: Department of Health Professions' New Investigative Regulations</b> ( <i>Norfolk Academy of Medicine</i> ). Medical Society of Virginia to 1) develop reasonable threshold for investigation of settlements and judgments reported to National Data Bank; 2) ask AMA to examine its position on need for threshold; and 3) if necessary, offer a resolution creating such a position.		✓✓		
<b>Resolution Z, Health Insurance Copayments</b> ( <i>J. Latane Ware, MD</i> ). Medical Society of Virginia to seek legislation to base copayments on schedule negotiated with hospital by carrier and not on charges.	✓			
<b>YOUTH/SCHOOL HEALTH</b>				
<b>Recommendations 1 and 2, Report of the Rehabilitation Committee.</b> Medical Society of Virginia to urge members to support Disability Determination Services in its efforts to benefit disabled children and to cooperate fully in providing needed medical documentation.	✓			
<b>Resolution U: Services for Disabled Children</b> ( <i>Rehabilitation Committee</i> ). Medical Society of Virginia to assist Disability Determination Services achieve expanded allocation of benefits for disabled children.				X
<b>Resolution J: Childhood Immunizations</b> ( <i>Virginia Chapter, American Academy of Pediatrics, and Virginia Pediatric Society</i> ). Medical Society of Virginia to ask state to provide vaccines to qualified private practice providers at Health Department's purchase cost, providers to charge no more than this cost plus reasonable administration fee.			✓	



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# WINNERS

Of the many honors bestowed each year at The Medical Society of Virginia's annual meeting, one leads all the rest. It is the coveted Physicians' Award for Community Service, presented at the 1991 meeting in Williamsburg for the 29th time. As is customary, the name of the recipient was a closely guarded secret until the meeting neared its close, and even then President John A. Owen, Jr., who revealed the winner at the Saturday night banquet, kept the audience guessing until the last line of his introduction. Here is how he did it:

"I have had a wonderful year as the President of The Medical Society of Virginia. I have met so many folks all around the state and renewed many past acquaintances and old friendships. This year has bolstered my enthusiasm to new heights for this medical society as a whole, because this whole is made up of many professional, dedicated, hospitable and genuinely caring physicians.

"Each year—and this was no exception—there are many physicians deserving of the Community Service Award. But this year is very special to me, not only because I get to present the award, but because it is going to a physician whom I have known a long, long, time.

"A superb example of the Society's membership, he has actively supported his local society, his state society and our national association.

"Born and raised in Virginia, he has helped us and his community build a more compassionate future.

"Never straying far from his native state, this physician traveled to the U.S. Naval Hospital in Portsmouth and on to Duke University Medical School for his education, internship and residency. Obtaining his certification in general and thoracic surgery, he went on not only to just practice medicine but to become a medical leader at each stage in his

career.

"It's hard work to be a leader, but this physician is not daunted by hard work. He has held many titles and served with distinction on many boards. Only a partial listing includes: chief of surgery for the Community Hospital of Roanoke Valley and Roanoke Memorial Hospital; chief of staff for the Community Hospital of Roanoke Valley; chief of the thoracic division of Roanoke Memorial Hospital; chairman of the Bylaws Committee for The Medical Society of Virginia; member of the board of directors of the Medical Society of Virginia Review Organi-

zation; and member of the board of directors for the Carilion Health Systems. I could go on and on.

"But what I have always admired about this physician is his ability not only to wish for a better future for his and our children but to do what's necessary to create one.

"He is a deeply religious man who not only goes to church every Sunday but helped build a new church for his parish. He is a father who doesn't just attend PTA meetings once a year but is on the School Board and is chairman of its Long-Range Planning Committee. He doesn't just talk about world unity



Dr. Keeley (right) with Dr. Owen



but is on the board of directors of the National Conference of Christians and Jews.

"In 1967 the Roanoke Merchant Association awarded him the title 'Father of the Year.' And twenty-four years ago he was just beginning! In 1969 he was one of the founders of the Roanoke Area Drug Abuse Control Council. Since 1975 he has been president of the Virginia Tuberculosis and Respiratory Disease Foundation. Since 1978 he has been a clinical professor of surgery for the University of Virginia School of Medicine.

"In 1986 he was recognized as The Distinguished Alumnus of the Roanoke Catholic School. In 1988 he was the first recipient of the state award for Alumni in Service to Schools, presented by the Concilium for Catholic Education in the Diocese of Richmond.

"The recipient of this years' Community Service Award is a man to be admired and respected. And I know he is loved by many, including his 15—yes, 15—children.

"It give me great pleasure to be presenting The Medical Society of Virginia's 1991 Community Service Award to **Dr. Robert L. A. Keeley.**"

The second surprised honoree of the evening was **James L. Moore, Jr.**, the Society's Executive Vice-President. Praising Mr. Moore's 25 years of untiring service at MSV headquarters, the last decade of them as head of staff, Dr. Owen presented the genial Jim with a gold Seiko mantel clock, inscribed to commemorate the occasion.

Two physicians were honored during the House of Delegates' second session. From the Virginia Board of Medicine **Dr. Read F. McGehee, Jr.**, Richmond, received a plaque "in grateful recognition of his invaluable service" as a Board mem-



**Dr. Owen, Jim Moore with commemorative clock, and Mrs. Moore**



**Dr. McGehee (right) and Dr. Connor**

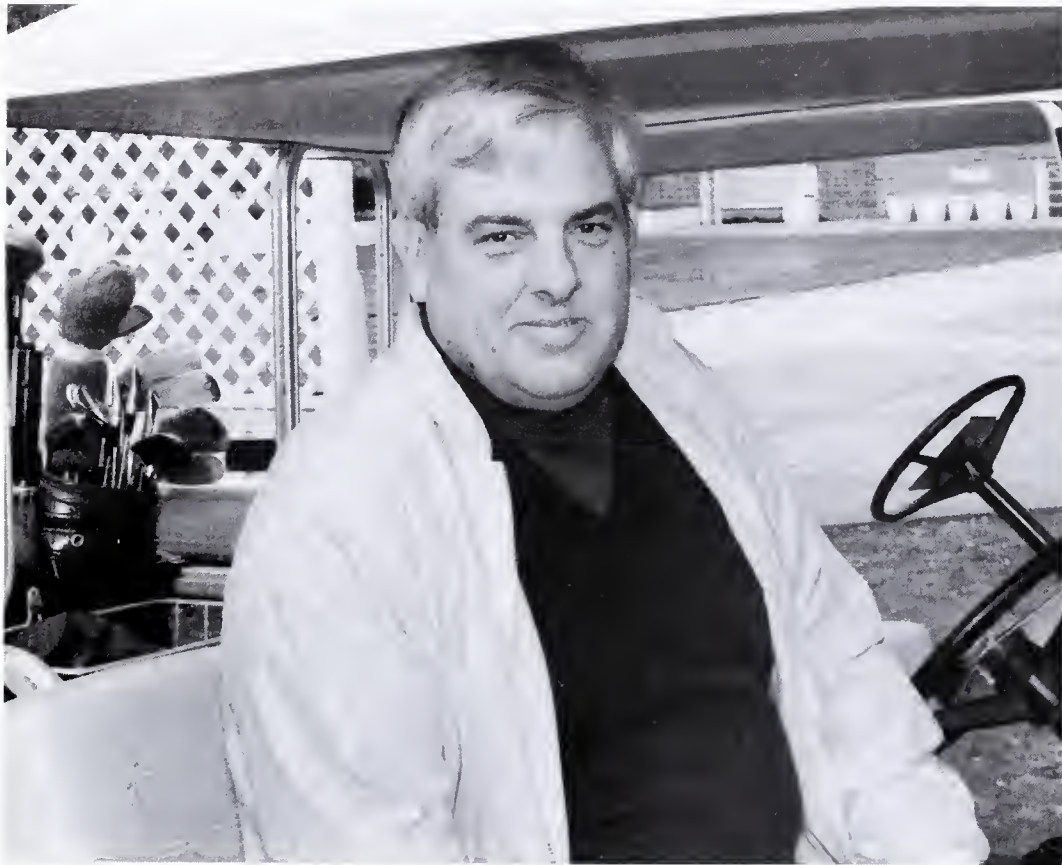
ber (1986-91) and president (1991), thereby "maintaining high standards of the Healing Arts." **Dr. Hilary H. Connor**, the Board's director, made the presentation.

"For his many contributions to medicine and to Virginia," **Dr. Raymond A. Brown**, Gloucester, was commended in a resolution read by **Dr. Charles A. Caravati, Jr.**, Rich-

mond. "Dr. Brown has served this Society for the past 15 years in every position of honor and responsibility this House could bestow, including the presidency in 1976 and AMA delegate since 1978," Dr. Caravati said, "and has served with distinction in each of them."

Introduced to the House by Dr.





Two-time champ Russ Stay

**Michael W. Russell**, Culpeper, were the new leaders of the Young Physicians Committee: **Dr. Joseph P. Leming**, Waverly, who succeeds Dr. Russell as chairman, and **Dr. Randolph J. Gould**, Norfolk, chairman-elect, who was also elected to an MSV vice-presidency.

Elsewhere in the Williamsburg Conference Center the judges had pinned some ribbons in the scientific exhibit section. First prize went to **Dr. Alton R. Sharpe, Jr.**, and Juliana Gerenscer of the Medical College of

Virginia for their exhibit on simultaneous determination of serum-free thyroxine and thyroid-stimulating hormone by radioimmunometric assay in the evaluation of thyroid function.

The American Cancer Society, Virginia Division, picked up the red ribbon for its exhibit on colon cancer control, and another MSV team, Jeanne K. Sanders, RN, and **Dr. Joseph R. Zanga**, placed third with their exhibit on a statewide system for injury surveillance in the pediatric office setting.



Dr. Leming (left) with Dr. Charles H. Crowder, Jr.

On the golf course, **Dr. Ellsworth J. "Russ" Stay** of Arlington won the Challenge Cup for the second year in a row by carding a 76 low gross. Prizes for second and third low gross went to **Dr. William W. Regan**, Richmond (91), and **Dr. Norman R. Edwards**, Newport News (92).

Low net prize-winners were **Dr. Wasfi A. Atiyeh**, Richmond (72), **Dr. Juan M. Montero II**, Chesapeake (75), and **Dr. George R. Smith, Jr.**, Shawsville (76).

**Dr. W. Wade Peery**, Galax, and Dr. Stay registered the longest drives, and Dr. Atiyeh and Dr. Stay drove closest to the pins.

Blustery weather wiped out the customary tennis tournament.

These lucky MSV members won prizes in the Technical Exhibit Section:

**Dr. Edward A. Barham**, Portsmouth, won a basket of Virginia products offered by Monette Information Systems. **Dr. Palmer W. Fant**, Independence, and **Dr. Ira D. Godwin**, Fairfax, won kaleidoscopes at the Haycraft Insurance Agency booth.

Two Richmond physicians, **Dr. L. E. Rennie** and **Dr. Donald P. King**, won leather briefcases, Dr. Rennie at the Sentient Systems booth and Dr. King at the Xelan exhibit.

At the Clements & Company booth, **Dr. Oscar W. Ward**, Hampton, won a book on Williamsburg and **Dr. Leroy S. McDaniel**, Richmond, won a box of golf balls. A book on Virginia was won by **Dr. Lewis S. Bridgforth**, Victoria, at the Saint Albans Psychiatric Hospital exhibit.

Mountainside Software's Cross pen and pencil set went to **Dr. James R. Holsinger**, Luray. IC System's credit manual was won by **Dr. Harry C. Beaver**, Annandale. **Dr. Esmail Rafi**, Fairfax, walked off with a Bulova watch at the John P. Pearl & Associates booth.





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# Clinicopathology Conference: Polymyositis and a Thalamic Mass

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From the Department of Medicine  
University of Virginia Health Sciences Center  
Discussed by Eugene C. Corbett, Jr., MD

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## PRESENTATION OF CASE

DR. RAY BRIG: The patient is an 81-year-old black male with a history of myocardial infarction and polymyositis who presents to the University of Virginia with a right thalamic mass. He was in his usual state of good health until June of 1987 when he was admitted for a right lower lobe pneumonia. The patient gave a history of approximately two months of progressive weakness, especially in the thighs, and an approximate 40-pound weight loss despite a good appetite. The patient was given IV antibiotics, was placed on a monitored bed, and was found to have an elevated CPK of over 3,000, most of which was from muscle. Further workup included a sedimentation rate elevated also at 78, hematocrit 31%, creatinine 1.8, normal TSH, negative ANA, and negative rheumatoid factor. The patient underwent a right quadriceps biopsy consistent with a chronic myopathy compatible with polymyositis. An EMG was also performed consistent with an active inflammatory myopathy. A bronchoscopy was also performed in which the biopsy returned no pathologic diagnosis, all cultures were negative, AFB smear was negative, and no malignant cells were seen. PPD was negative but had a reactive anergy panel. Further malignancy workup revealed normocellular bone marrow. An SPEP revealed a polyclonal gammopathy.

Shortly after his discharge the patient was seen in the Arthritis Clinic and given a diagnosis of idiopathic polymyositis. He was started on prednisone 30 mg bid in view of his progressive disease. After 3 months on therapy the patient had no improvement of his proximal muscle weakness. Prednisone was tapered off and azathioprine 50 mg twice a day was begun. The patient returned in April of 1988 complaining of back pain. He admitted medication noncompliance and was restarted on azathioprine. A bone scan revealed degenerative changes of his facet joints at the L4, L5 level. Azathioprine was subsequently stopped and a course of methotrexate and prednisone was tried for several months but without significant improvement. Eventually in the summer of 1989 he was switched to cyclophosphamide and remained on his prednisone at 20 mg once a day.

The patient maintained his baseline state of health until September 1989 when he was admitted to an outside hospital with bright red blood per rectum. A right hemicolectomy was performed to control bleeding. Pathology showed chronic diverticular disease but no other specific lesions. The patient did well postoperatively and was discharged. At home, however, the patient had complaints of increasing weakness and on November 6, 1989, the patient fell while he was in the bathroom. This episode was witnessed by his sister who stated there was no loss of consciousness. She did note some decrease in level of mental functioning over the previous several weeks with poor memory and some degree of disorientation. The patient was

Presented on March 6, 1991. Address correspondence to Dr. Corbett at Box 494, University of Virginia Health Sciences Center, Charlottesville VA 22908.



brought to an outside hospital and a CT of the head was performed which revealed a right thalamic mass (Fig. 1). He was subsequently transferred to the University of Virginia for further evaluation.

*Past Medical history:* 1. Polymyositis for two years. 2. Status post myocardial infarction  $\times$  2 with an echocardiogram which revealed 4-chamber enlargement with severe LV dysfunction with an estimated ejection fraction of 15%. 3. Status post cholecystectomy 10-12 years ago. Medications on transfer included Dilantin®, Decadron®, Carafate®, and ferrous sulfate. Social history is most notable for 150-pack/year of tobacco use. Family history noncontributory. Review of symptoms significant for 18-kg weight loss the past 2 years.

*Physical exam:* The patient was a disheveled black male in mild respiratory distress with a BP of 110/70, HR 100 and regular, RR 24, T 37.8°C. HEENT exam revealed pupils symmetrical and reactive to light. Oropharynx revealed evidence of oral candidiasis. Lung examination revealed decreased breath sounds in the left base. Patient's cardiac exam revealed a regular rate and rhythm and a systolic ejection murmur was noted along the left sternal border. His peripheral pulses were intact and symmetrical. Abdominal exam revealed a well-healed transverse scar. No organomegaly or masses were appreciated. The patient had no evidence of adenopathy. Extremities showed no evidence of clubbing, cyanosis, or edema.

*Neurological exam:* the patient was oriented to place but was unable to state the proper month. Motor exam revealed 5/5 strength of the right upper extremity, 4/5 strength of the left upper extremity, and 3+ to 4/5 of both lower extremities. Sensory exam was difficult given patient's poor cooperation. Cerebellar function grossly intact. DTRs were symmetrical.

*Laboratory data:* Sodium 135, potassium 5.2, BUN 27, creatinine 1.8, chloride 104, CO<sub>2</sub> 25, glucose 118, white count 3.3 with 64% neutrophils, 21% lymphocytes, 9% monos, 1% eos. Hematocrit 25.5 with an MCV of 91 and a platelet count of 102,000.

*Hospital Course:* The patient was admitted to the neurosurgical service for further evaluation. A chest x-ray revealed mild cardiomegaly without evidence of pulmonary vascular congestion or pulmonary edema. There was some increased markings noted at the right lung base which appeared chronic in nature. An MRI scan demonstrated an enhancing mass in the region of the right thalamus associated with a moderate amount of edema and mass effect with displacement of the lateral and third ventricles (Fig. 2). The patient remained afebrile during his first several days at the University of Virginia. He was continued on Decadron and Dilantin. His neurologic status remained stable and a diagnostic procedure was performed.

**RADIOLOGY**

DR. MAURICE LIPPER: Based on the radiological fea-

tures of a well-defined enhancing thalamic lesion surrounded by edema, the most likely differential diagnosis in an immune-compromised patient rests between inflammatory and neoplastic disease. The most frequent cause of such lesions in an HIV-positive patient

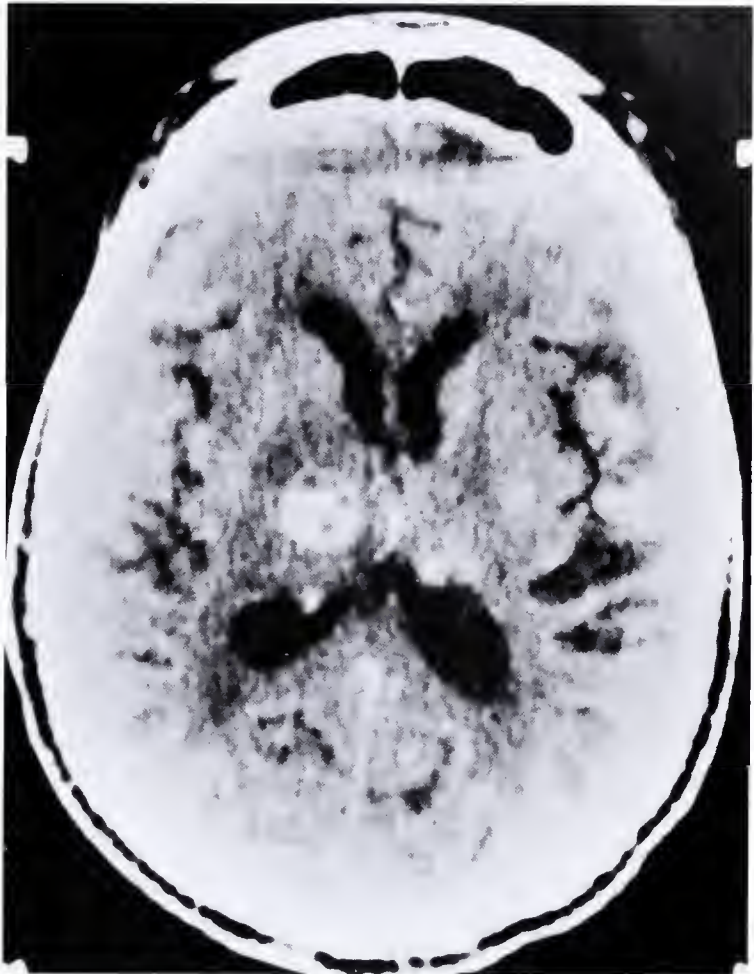


Fig. 1. Contrast CT scan shows a rounded nonhomogeneously enhancing lesion in right thalamus with surrounding low density consistent with edema.

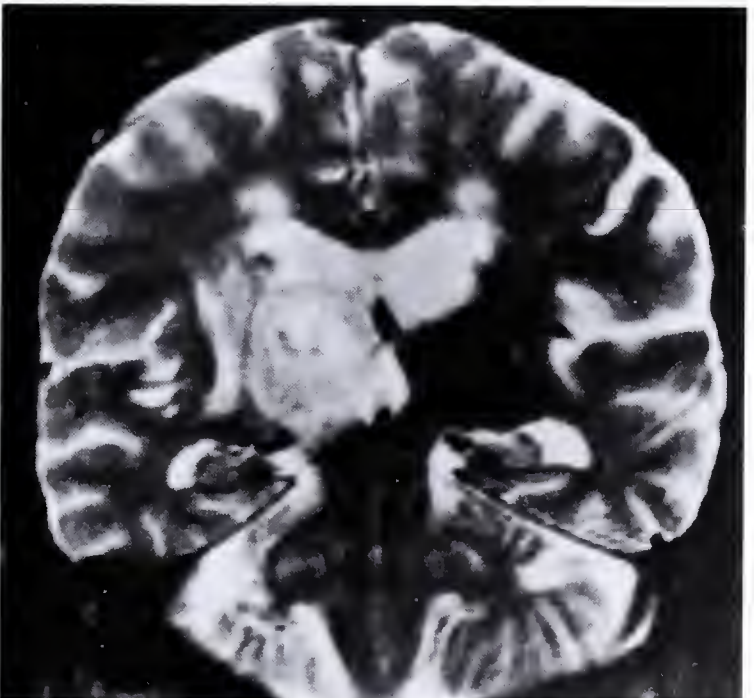


Fig. 2. Coronal T2-weighted MR image (TR 2500 msec/TE 90 msec) demonstrates high-signal intensity lesion in right thalamus with surrounding edema causing mass effect on third and right lateral ventricles.



is a *Toxoplasma gondii* infection. In a series of 200 patients with AIDS studied radiologically, a positive histopathologic diagnosis was made in 45.<sup>1</sup> Of these, 22 had toxoplasmosis, either alone (22 patients) or in conjunction with primary CNS lymphoma (5 patients). The most common CT finding seen in toxoplasmosis was a large low area of density with central ring enhancement. The lesions were multiple in 11 patients and the most common site was the basal ganglion region. The MRI appearance is that of a low signal intensity lesion with central enhancement following intravenous administration of gadolinium-DTPA on T1-weighted images. T2-weighted features are those of a high signal intensity central lesion surrounded by high signal intensity edema.

Lymphoma is usually the second most common lesion in these patients. Although the usual CT and MR appearance of primary intracranial lymphoma is that of an intensely enhancing paraventricular lesion surrounded by edema, the appearance in AIDS may be identical to that of toxoplasmosis. Because of the atypical reaction in such patients, the usual CT and MR criteria may be altered and not diagnostically pathognomonic, and stereotactic CT-guided biopsy is often necessary.<sup>2</sup> This factor also mitigates against treating such lesions empirically either for toxoplasmosis or lymphoma.

### CLINICAL DISCUSSION

DR. CORBETT: In considering the general etiology of a thalamic mass, a neoplastic lesion, whether primary or metastatic, should be considered. Infectious disease also is a possibility but localized in the CNS rather than diffuse. An inflammatory lesion localized to the deep brain should also be considered. Vascular lesions should be included in the differential diagnosis, particularly in an elderly age group. And finally, congenital phenomena such as a porencephalic cyst or hamartoma might also be considered.

We will now search for clues within the patient's extensive problem list as to more specific etiologic possibilities. The patient had 14 problems. His presenting problem is a right thalamic mass with weakness, particularly in the left upper extremity, and dulling of the intellect. Any 81-year-old individual with this presentation should be suspected of having either a neoplastic lesion, a focal infection or some local vascular lesion. A congenital abnormality would be unlikely to be present for all these years and then suddenly present as a newly active mass.

A collection of pulmonary-related phenomena form his second problem. The patient's 2-pack a day smoking history for more than 70 years in association with his well-documented chronic pulmonary disease makes him eligible for a metastatic pulmonary neoplastic lesion. His right lower lobe pneumonia in 1987 with subsequent chronic right lower lobe changes raises the possibility that he has an indolent infectious

process such as aspergillosis, which now has seeded deep to his cerebral hemispheres.

The patient's third problem is that he had a myocardial infarction twice and now has a 4-chamber cardiomyopathy with an ejection fraction of 15%. We should therefore entertain the possibility that he embolized a clot to his brain from the left ventricle. Alternatively, he might have bacterial endocarditis with a secondary CNS localized infection.

The patient had well-documented polymyositis in 1987. This diagnosis was substantiated by muscle biopsy and corroborated by EMG and an elevated CPK. Is it likely that this is a paraneoplastic syndrome? Polymyositis generally occurs in four settings, most typically in the 30-50 age group, predominantly among women, and generally tends to be steroid responsive. Polymyositis also occurs with malignancy, generally in males over 50 years of age in a form that tends to be less steroid-responsive, and also occurs in childhood and in association with collagen vascular syndromes. Serologies to suggest the latter were not documented in this gentleman. The diagnosis of polymyositis should help us in the final analysis of this case or, at the very least, it should be explained by whatever final hypothesis we choose.

We are told that the patient had chronic immunosuppressive therapy since 1987. This involved an almost continuous 2-year period of prednisone. He was also for a number of months on a changing combination of azathioprine, methotrexate and cyclophosphamide. Such degree of immunosuppression raises both neoplastic and infectious possibilities. Non-Hodgkins lymphoma, although rather rare, can occur in this setting. This usually presents as a single deep brain CNS lesion. Also, even though we are not told whether he is HIV-positive, a smoldering infectious process becomes possible with chronic immunosuppression.

The patient has had mild chronic renal failure since 1987. However, his creatinine of 1.8 has not changed appreciably over that 3-year period. I don't believe this is a clue to any particular etiologic factor in regard to his CNS lesion.

We are also told that he has had anemia since 1987; it appears to be progressive because of the hematocrit decrease over that period of time. This might be related to his chronic renal failure. Alternatively it may simply be a manifestation of a slowly developing neoplastic disease. His eighth problem is one of polyclonal gammopathy, again noted in 1987. Although this may accompany a chronic infection, it may also be associated with chronic inflammatory diseases. Sarcoidosis comes to mind and should be considered as well.

We are told that the patient lost weight prior to the diagnosis of polymyositis in 1987. The protocol suggests that he again lost 18 kg of weight over the two-year period since 1988. Weight loss and anemia in



an elderly man points to either an infectious or, more importantly, a neoplastic disease.

In 1989 the patient was noted to be leukopenic and thrombocytopenic. This may be a development associated with the anemia and indicate a myelophthitic process. The monocytosis which was also noted in 1989, however, may indicate a chronic infectious etiology. The eleventh problem is quite important. The patient was noted to have oral candidiasis at the time of his presentation in 1989. Generally, oral candidiasis is not seen in elderly individuals except in those who are significantly immunocompromised, are in the throes of terminal illness, or on broad spectrum antibiotics. It is less frequently observed when steroid administration alone continues on a chronic basis. Its presence suggests that he has a smoldering infectious disease to account for his CNS lesion.

Two months prior to his presentation the patient was noted to have diverticulosis coli requiring a hemicolectomy because of bleeding. Could this be a clue to an infectious disease that began during his surgery? Perhaps some smoldering fungal disease gained access to his vascular system at that time and now presents as a thalamic lesion? Finally, he had a cholecystectomy in the late 1970s. If he had a transfusion at that time, perhaps this could have resulted in a chronic immunosuppressive disease such as AIDS, but we are not told that he is HIV-positive and such a possibility would be extremely unlikely in this age group.

This patient's problem list suggests no evidence of a congenital phenomenon; indeed, to present with a thalamic mass associated with neurological changes at the age of 81 makes a congenital lesion quite remote, and I am not going to consider this in the differential.

Thus 20 possibilities comprise the expanded differential diagnosis. Under the heading of neoplasia, an astrocytoma or other glial tumor conceivably could develop in the thalamic region; 15% of astrocytomas are found in the basal ganglia, thalamus or globus pallidus. A non-Hodgkins lymphoma should also be considered in the differential. These otherwise rare lesions usually occur in immunocompromised hosts.<sup>3</sup> They present classically in the deeper parts of the brain such as the thalamus and globus pallidus. The appearance is quite consistent with this patient's MRI scan.

He may also have a metastatic lung lesion. The neurosurgical literature indicates that 45% of presenting metastatic lesions in the deep brain originate from the lung. His history of long-time smoking in the setting of chronic lung disease, weight loss and anemia are very suggestive of advanced carcinoma of the lung. Perhaps most importantly, a paraneoplastic nature to explain his polymyositis makes for a tidy diagnostic explanation. A metastatic pancreatic lesion should also be considered in any male who presents with these clinical features. However, we have no evidence for pancreatic disease. The patient underwent laparotomy two months prior and we are told that no other

problems were found at that time. We should also consider a nasopharyngeal metastatic lesion. The patient was a smoker for many years and the risks for this kind of cancer are similar to those of carcinoma of the lung. However, we would have expected some supporting information from the history or physical to suggest this possibility. There is none. Metastatic prostate should also be considered in an elderly male with a brain lesion and a neoplastic profile. However, these lesions usually metastasize to the bone first. Also, we are not given the result of his rectal exam in the protocol, making this an unlikely consideration in the case. A similar argument pertains to metastatic malignancy from the colon. He is an elderly man with known diverticular disease, a marker epidemiologically associated with carcinoma of the colon. It is the third most common malignancy in males. However, it is unusual for colon carcinoma to metastasize to the brain before going to the liver or lung. In addition, we are told that he had no other lesions when he underwent his recent laparotomy and hemicolectomy.

A focal CNS infection must be considered in the differential diagnosis of an immunocompromised host.<sup>4,5</sup> Viral possibilities are ruled out simply because they do not present in a focal pattern. It seems unlikely as well that he has a bacterial abscess since his course appears to be subacute or chronic in nature.<sup>6</sup> In addition, the MRI scan is not typical for an acute brain abscess nor does he have headache or fever, evidence that we would look for in such an acute situation. Immunocompromised individuals can have listeriosis, which can present as a subacute process in an immunocompromised host. However, it almost invariably presents as meningitis and/or encephalitis.

Could the patient have a mycobacterial tuberculosis? This should be considered; however, tuberculous disease in the CNS almost always presents as a gelatinous meningitis and the MRI scan does not suggest this possibility. Moreover, tubercular abscesses generally behave clinically like bacterial lesions. Could the patient have a nocardial infection? He is an immunocompromised host, has background pulmonary disease and a cerebral lesion. I think this possibility is unlikely. In addition to the fact that nocardia is quite rare, he has no obvious pulmonary lesion that is suggestive of nocardial disease and cerebral nocardial abscesses are usually multiloculated. The MRI scan suggests that this is not the case.

Could he have toxoplasmosis? This intracellular protozoan can present as a focal CNS disease in the immunocompromised host, particularly deep in the brain around the basal ganglia and thalamus. Although this disease often presents as a fulminant necrotizing encephalitis in an immunocompromised individual, a localized disease presents a very intriguing option.<sup>7</sup> It is the most frequent opportunistic infection in the immunocompromised host, such as occurs in AIDS. The MRI picture is quite consistent and so is the



clinical course. We apparently don't see any hemorrhage in the lesion, an observation which is frequently made on MRI scans of toxoplasmosis. Nevertheless, this possibility certainly should be considered. Cryptococcosis can present as a smoldering disease in an immunocompromised host and can result in an occasional abscess in the CNS. However, this is almost invariably associated with a basal meningitis and skin lesions. The patient has neither of these and I don't think this possibility is likely. As mentioned previously, aspergillosis is a possibility. It is a fungal disease that should be considered in the setting of an individual with emphysematous lungs, which is immunocompromised and has a focal cerebral lesion. It could be consistent with both the MRI scan and the course of the patient's disease and should be considered. Mucormycosis can also present as a cerebral mass in an immunocompromised host but this is usually in the setting of a contiguous rhinocerebral lesion and is usually seen in diabetes, which this patient does not have. And finally, could the patient have candidiasis? He has been documented to have oral candidiasis, he is immunocompromised and has a cerebral lesion. However, candidiasis which gives rise to CNS lesions usually occurs in the setting of disseminated candidiasis. In this regard, he does not seem ill enough for this diagnosis and he does not have evidence of skin, genitourinary, heart or renal candida lesions. Also, disseminated candida usually gives a multifocal pattern on the MRI and candidiasis is usually associated with meningitis, an observation which has not been made in this particular patient.

The only inflammatory lesion that might be considered is sarcoidosis. This can present as a myopathy associated with an increased gammaglobulin, anemia and an inflammatory lesion in the vicinity of the thalamus. I don't think this possibility is likely, however. This patient seems quite old to invoke this diagnosis and his muscle biopsy was negative for granuloma and more consistent with a non-specific polymyositis. As well, the brain mass localization should be suprasellar rather than intraparenchymal and the eye consultants did not see evidence of uveitis. This possibility is therefore quite unlikely.

And finally, could the patient have had a vascular lesion? Three possibilities exist. Could he have had a traumatic hemorrhage? He is a weak elderly man who fell in the bathroom and could have struck himself on a rather hard surface. He also is noted to be thrombocytopenic. The likelihood of this lesion is very small, however, since most of these lesions would be expected to be subdural and not deep in the brain. I am told by Dr. Lipper that had he had a traumatic hemorrhage, we should see evidence of more superficial damage to the brain. There is none.

Could he have had a spontaneous hemorrhage or infarction as a result of either thrombosis or embolization? Certainly this should be considered in an elderly

person with known vascular disease (coronary) and a cardiomyopathy. However these lesions are usually seen in the distribution of the middle cerebral artery rather than deeper in the basal ganglia. The lesion in this gentleman seems unusually large, with a significant mass effect in comparison to what would be expected with either embolization or thrombosis. He is not hypertensive, and thus a lacunar infarct, which would otherwise occur in this area and is usually much smaller and often wedge-shaped, is not likely. Finally, an arteriovenous malformation should be considered because of the possibility that a large mass in this area could be a bleeding AVM. However, the MRI scan, which is usually very specific for this kind of lesion, does not indicate this is the case.

Thus we are left with five final choices to explain this patient's thalamic mass: a primary glial tumor, a non-Hodgkins lymphoma, a metastatic lung lesion, toxoplasmosis or aspergillosis. Which one could it be?

A primary astrocytoma is an interesting possibility and it certainly could be consistent with the patient's neurological course and his MRI. However, it doesn't explain very well the patient's overall neoplastic profile, nor does it seem to be specifically related to his immunocompromised state or his polymyositis. Also, the MRI margins on this lesion appear rather smooth for an enhanced lesion. Generally, astrocytomas that are high-grade and therefore enhance, tend to infiltrate. Irregular margins are expected. This is the least likely of the five possibilities.

It is more intriguing to consider a non-Hodgkins lymphoma. This is particularly consistent with the MRI features, the deep brain location and the fact that the patient is immunocompromised. However, it has no specific connection to polymyositis and therefore is not a compelling explanation.

From the standpoint of the natural history of the patient's disease, I must give a strong vote to a secondary metastatic lung lesion. It would indeed account for polymyositis as a paraneoplastic phenomenon. We know from the literature that polymyositis can present up to two years before the primary neoplastic lesion in approximately 70% of cases. Lung cancer can also present initially in the brain in a large minority of cases.

Toxoplasmosis gets the other strong vote as a final possibility. It can assume a deep brain location in an immunocompromised host who is also manifesting oral thrush. Toxoplasmosis is the most frequent infection in such patients, as illustrated by the AIDS population. The MRI scan appearance is quite typical and quite convincing. There is some connection to polymyositis in that patients with polymyositis generally have more frequent evidence of toxoplasmosis antibodies. Some sources in the literature believe that it may play a causative role in the occurrence of polymyositis.

Finally, aspergillosis could be consistent with the MRI and the course of the illness. However, it does not



explain very well the other features of the patient's illness; there is no well-defined pulmonary lesion and he has not had hemoptysis. It therefore is less likely an explanation.

Given all considerations, with particular attention to the fact that the patient is immunocompromised, my choice is that the patient was demonstrated to have CNS toxoplasmosis via a scan-guided needle biopsy of the lesion.

### DIAGNOSIS AND PATHOLOGY

DR. BENJAMIN STURGILL: I will begin by showing you the biopsy of the right quadriceps muscle performed during the patient's first admission. There is a myositis characterized by an interstitial infiltrate of lymphocytes and plasma cells (Fig. 3). No specific etiology is evident from the sections and in the absence of other clinical evidence in support of a specific etiology, a diagnosis of idiopathic polymyositis was made.

The diagnostic procedure performed most recently, as the radiologist has already indicated, was a stereotactic biopsy of the lesion in the right thalamus. This is an inflammatory lesion with granulomatous features and careful examination disclosed characteristic cysts of *Toxoplasma gondii* (Fig. 4).

DR. BRIG: The patient had an HIV antibody test performed as part of the neurosurgery preoperative evaluation. The test was noted to be positive the afternoon after the surgery and the pathologists were subsequently informed of this finding. The pathologist found evidence of toxoplasmosis on both the H&E and immunoperoxidase stains. It was felt in retrospect that the patient's risk factor for acquiring HIV positivity was the cholecystectomy performed in Connecticut in the late 70s in which he received blood transfusions perioperatively.

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Fig. 3. Myositis characterized by interstitial infiltrate of lymphocytes and plasma cells.

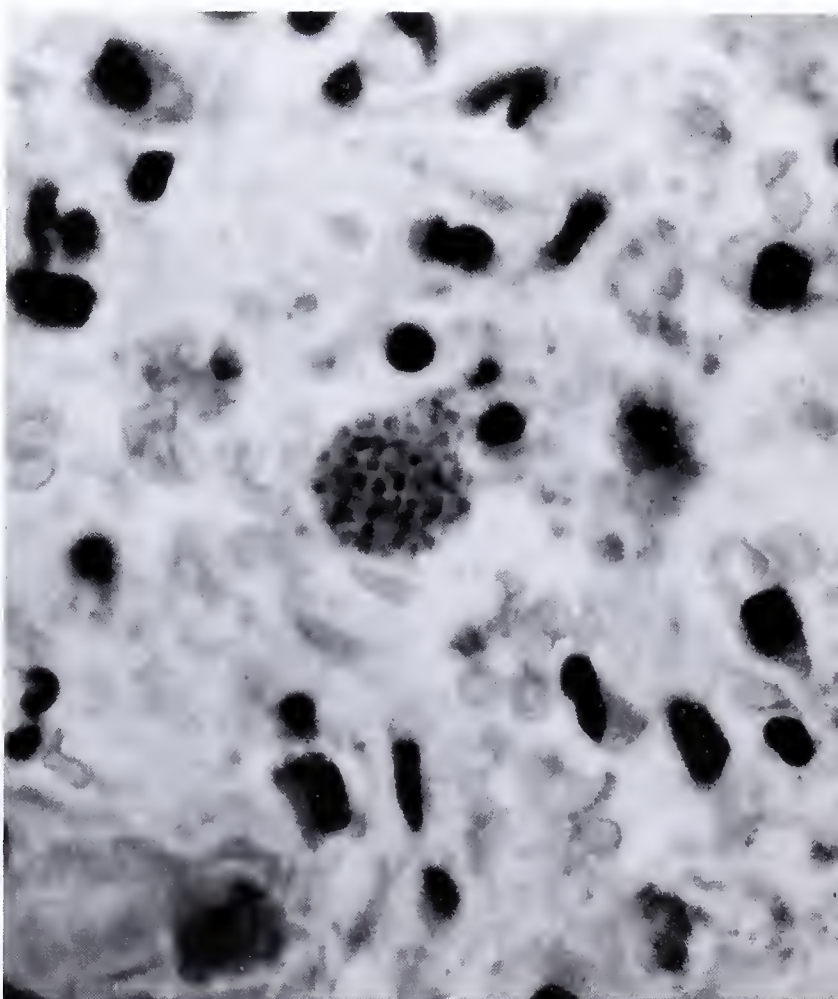


Fig. 4. Inflammatory lesion with granulomatous features and characteristic cysts of *Toxoplasma gondii*.

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# A Winning Indigent Care Program

Samuel T. Selden, MD, and  
Nancy M. Welch, MD, *Chesapeake, Virginia*

A GOOD indigent care program should be locally run, satisfying local needs. Eligibility standards should target those in greatest need. A good program should also provide continuity of care as well as both acute and preventive care, and do so on a volunteer, not mandated basis.

Chesapeake's Coordinated Health and Medical Program (CHAMP) effectively joins elements of indigent health care into an innovative coordination of grass roots solutions. Established in 1989 with the assistance of the Chesapeake Medical Society, the CHAMP program integrates existing community resources into a public-private partnership that emphasizes outpatient preventive measures as an alternative to more costly emergency room or inpatient care. Under the plan, adult health maintenance, preventive, and chronic care are delivered by the Chesapeake Health Department, with records of visits mailed to the designated/selected primary care physician. The physician provides episodic care as well as consultative recommendations when abnormalities are detected during a health department visit. Shared records contribute to the partnership spirit. At the present time, 61 private physicians volunteer their services. Primary care physicians, surgeons, and specialists accept patient referrals. Some specialists hold select clinics within the CHAMP facility itself. Basic laboratory services are provided through the health department. Chesapeake General Hospital has contributed \$25,000 to defray costs of more sophisticated radiological or laboratory testing to be performed at the hospital. This hospital's medical staff has donated monies to assist in the provision of a partial pharmacy program, whereby nonacute medications are provided at free or reduced cost.

Physicians on the Professional Advisory Board oversee the medical care component and serve as liaison between the health department and the private providers. Patient advocacy is served by a Community Advisory Board. Clinic manpower includes a nurse practitioner, two nurses, a laboratory technician and appropriate support personnel. Recruitment is in the process for a full-time family practice physician. All personnel, supplies, and rental costs are absorbed by the City of Chesapeake.

Dr. Selden is a dermatologist in practice at 200 Medical Parkway, Suite 309, Chesapeake VA 23320. Dr. Welch is district director of the Chesapeake Health Department.

As initially crafted, this program can serve as a model of local indigent care for other communities. It is a coalition effort, locally created and locally administered. There have been no mandates. The savings spread beyond the low costs of providing the program. By providing preventive care, by keeping patients out of emergency rooms and expensive inpatient care, savings are felt throughout the community. Because of its structure and early successes, the CHAMP concept was endorsed by the Medical Society of Virginia.

In the Spring of 1991, moreover, Virginia's General Assembly added an incentive for the business community to join the coalition when it passed HB1949. This law permits the establishment of CHAMP, Inc., a nonprofit entity, through which businesses may help underwrite an indigent pharmacy in Chesapeake. Eligibility through the Neighborhood Assistance Act permits these contributing businesses to receive a 50% tax deduction credit.

SO WHO are the beneficiaries of the program? To date, 757 patients are enrolled, with close to 300 on the waiting list. Over 3,000 clinic visits are scheduled in addition to outreach and home visitation. Approximately 42% of the patients are from working families; however, only 11% have a third-party insurance source. Close to 90% of the patients are being followed for either hypertension or diabetes, and over 1,200 prescriptions are written per year. Seventy percent (70%) of the hypertensive patients are now stable, although the majority of them were uncontrolled when they first entered the program.

To put it succinctly, CHAMP is a Winner! It's grassroots, it's integrative, it's effective—and at a little less than \$700 a patient, it's also economical. Start-up costs are minimal, and there are no governmental dictates. This program is flexible, adaptable, and totally controlled at the local level. It is on line, is succeeding, and could work in other communities throughout Virginia.

**Editors' Note:** There are 15 other indigent care projects in Virginia, all sponsored by component medical societies: Albemarle County Medical Society (operated by Jefferson Area Board for Aging); Alexandria Medical Society; Arlington County Medical Society; Augusta-Highland Counties Medical Society; Culpeper County Medical Society; Fairfax County Medical Society; Floyd County Medical Society; Hampton Medical Society (managed by Peninsula Agency on Aging); Lynchburg Academy of Medicine (operated by Central Virginia Area on Aging); Newport News Medical Society; Norfolk Academy of Medicine; Northern Virginia Medical Society; Richmond Academy of Medicine; Roanoke Valley Academy of Medicine; Virginia Beach Medical Society. The Hampton and Newport News Societies also cooperate in a voluntary referral plan to provide primary care for HIV-infected patients (*Arch Intern Med* 1991;151:2061-64).



# Public Safety: Virginia's Impaired Drivers

Howard McCue, Jr., MD,  
*Richmond, Virginia*

**O**F THE MORE than 4 million automobile drivers in the State of Virginia, 25,000 are under medical control. To encompass the problem, constant vigilance must be exercised by the Department of Motor Vehicles and by the community of Virginia physicians who report impaired drivers.

In determining the driving capability of medically impaired drivers, the Board applies the minimum restriction consistent with personal and public safety. The guiding principle is individual case consideration, and the primary emphasis is on functional capacity rather than diagnosis. All available findings are carefully reviewed, and additional information may be sought. Some conditions permit safe driving if there are appropriate limitations (i.e., daylight driving, specially equipped vehicles, etc.) The medical profession is the key link to the Board's decision, and the cooperation of involved doctors is greatly appreciated.

There are four general categories of conditions affecting the ability to drive:

- Conditions altering level of consciousness, such as seizure disorders, cerebral vascular accidents, hypoglycemic episodes, alcohol and drugs, etc.
- Conditions altering perception, primarily vision; other perceptions are of lesser importance.
- Conditions altering judgment, such as central ner-

Five Virginia physicians who set policy and deal with medical problems affecting drivers in Virginia are pictured at right. At the extreme left is Dr. Howard McCue, Jr., consulting physician to the Department of Motor Vehicles' Medical Control Unit. At the extreme right is Dr. John B. H. Caldwell, Richmond, chairman of the DMV's Medical Advisory Board, whose members are appointed by Virginia's governor. Between them are two more Board members: Dr. Augustine W. Lewis, Aylett (left); Dr. John R. Taylor, Richmond; and Dr. Harold T. Green, Richmond. Three members of the Board were not present for this picture: Dr. Lee R. Brock, Fredericksburg; Dr. Donald W. Drew, Norfolk; and Dr. M. Stephen Kramer, Richmond.

Photograph by Cyane Lowden

vous system deterioration, aging/senility, psychiatric illness, personality disorders, substance abuse, etc.

- Motor defects, such as injury, amputations, degenerative neuropathies, congenital defects, joint disease, etc.

In all these categories, accurate medical information from the driver's doctor is essential for appropriate action. Objective testing of driving performance may provide vital information or resolve apparent conflicts in many of these conditions.

Here following, in the order of frequency, are the medical problems that caused suspension of drivers' licenses in Virginia in 1988.<sup>1</sup>

**1. Seizure Disorders.** The physician's report should include the nature of the seizure; frequency and date of the most recent episode, diagnostic data (i.e., EEG result), treatment program and patient compliance, and significant complications. With this information the DMV can give proper consideration. The majority of patients with this condition can be controlled and drive safely as a result, but periodic review is necessary to assure adequate control is being maintained.

**2. Visual Disorders.** Vision is the most important sensory function in the operation of a motor vehicle. For unrestricted license, the current requirements are:

*Visual acuity: 20/40 or better in one/both eyes.  
Horizontal visual field: 100 degrees or better.*

Simple deduction leads to the conclusion that visual field is more important to driving than visual acuity. For instance, a person with visual acuity of less than 20/70 but with normal visual fields (horizontal 170-180 degrees) can probably drive safely, whereas a person with 20/20 and tunnel vision (or very narrow visual fields of 20-30 degrees) cannot.

Five years ago Virginia's General Assembly legislated a program so that persons with quite low visual





When is a driver too old to drive? Some drivers must be restricted at age 55. Others function well at 90. The suggestion that all drivers age 70 and over should be tested frequently has little scientific basis. True, older people suffer more medical problems than the young or middle-aged, but most of these problems have little impact on the ability to drive, and it is now accepted that older drivers do not have the poor accident or driving records so often attributed to them in the past. This seems likely to be the result of compensations that older drivers make to adapt to the changes of age. As a rule they drive less, avoid congested traffic, drive during daylight hours, and avoid high speeds.

H. McC., JR.

acuity (i.e., 20/200) might qualify for a license with the aid of a bioptic telescopic lens (usually 3-4 power) if acuity were thereby improved to 20/70 or better. If the licensee's acuity reaches 20/40 after one year's experience with this device and if the licensee passes a night-driving test, he or she may be given permission to drive at night. This device is attached to or integral with the driver's eyeglasses.

It seems clear from what has been learned in recent years that there is need for further study of the role of visual acuity in driving a car safely, and it is the hope of the Medical Advisory Board that such a study will be authorized.

**3. Psychiatric illness.** Significant psychiatric disorders are fairly common. Treatment success, particularly with psychoses, is variable. Adequate medical reports are vital. The DMV can resort to careful testing of its own in questionable cases.

**4. Complications of Diabetes.** The problem with diabetics is primarily that of insulin reaction leading to hypoglycemia. A percentage of these patients have little prodromal warning, and such an episode when driving usually leads to an accident. Sufficient time

must be allowed to establish that control is in the proper range. Patient cooperation, including frequent checks of blood glucose level, can make a difference in the patient with a relatively severe case of diabetes.

**5. Cardiovascular Disease.** Most patients with heart disease are not limited in driving performance, but a major arrhythmia can be a problem. Pacemakers have often solved this.

**6. Organic Central Nervous System Disease.** CNS degeneration can be a major concern, particularly when the individual is not capable of recognizing changes and function deteriorates to a serious level. The cooperation of physician and family become critical, and both may have difficulties with these patients.

**7. Stroke.** The residual loss after a cerebral vascular accident is the controlling factor in the capacity to drive. Medical reports plus testing can usually determine the ability to perform safely. Rehabilitation may play a major role.

**8. Alcoholism and Drug Abuse.** These are obvious problems and not easy to deal with.

**9. Other Conditions.** Amputations, paraplegia and other paralytic changes pose mechanical questions. Specially equipped vehicles (i.e., all hand controls) may allow these persons to drive safely. The level of performance can be measured.

## Summary

Through its licensing procedure, the Department of Motor Vehicles plays a key role in the preservation of personal and public safety. Restriction of license to drive is limited to that necessary to assure this safety. Most people can drive safely and should be allowed to do so. Constant vigilance and the cooperation of physicians, family, police, and other drivers is needed to identify those persons whose ability to drive is questionable for medical reasons. Each case receives individual consideration by the Board. Adequate medical information is critical to the decision. The DMV's Medical Control Unit is available by telephone at 804-367-6639 or by mail at PO Box 27412, Richmond VA 23269-0001.

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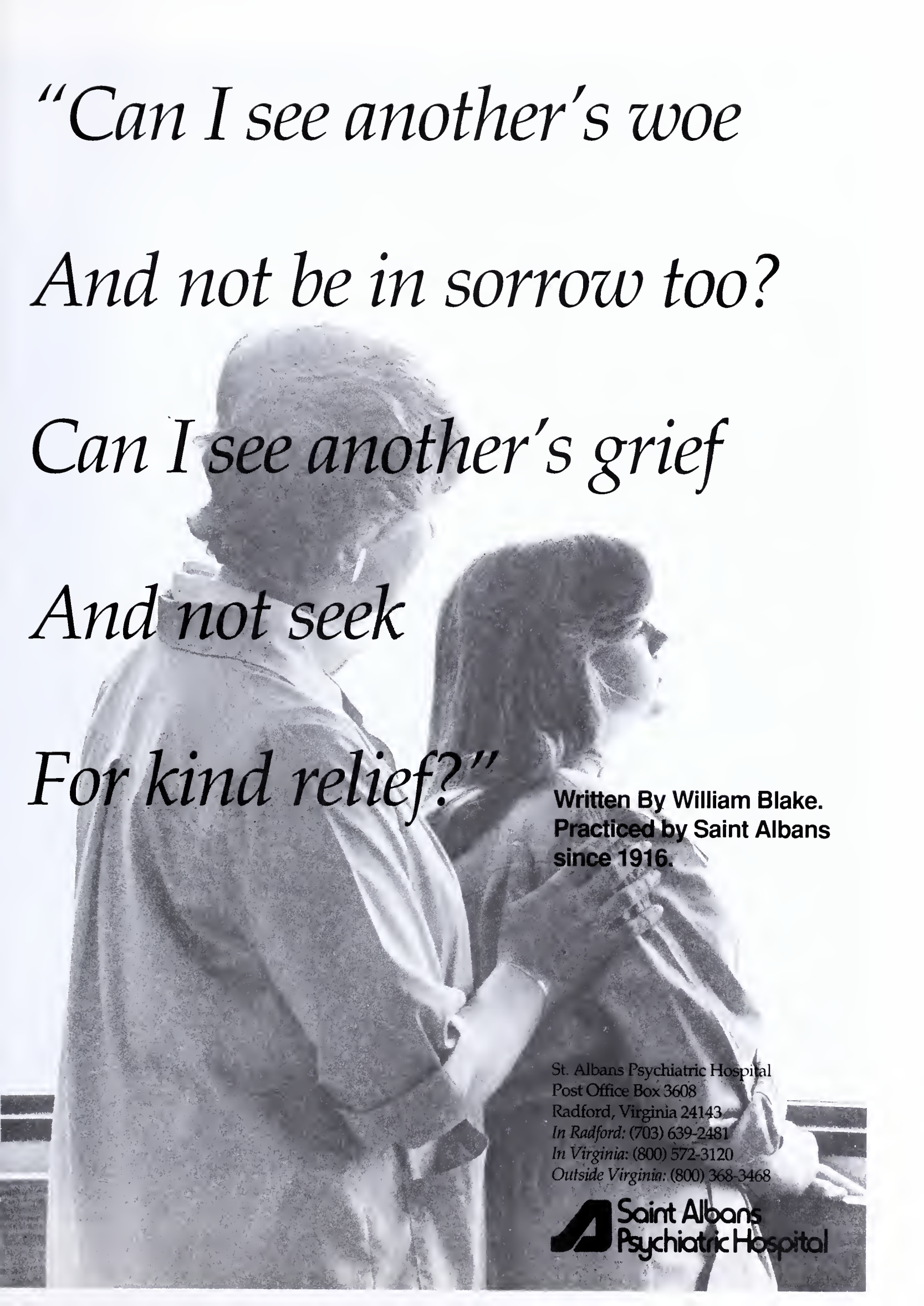
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# VIRGINIA MEDICAL

## President Hollowell

**W**HEN John W. Hollowell assumed the presidency of the Medical Society of Virginia in November, he brought with him an acknowledged dedication to the field of medicine as well as to Virginia and his hometown of Portsmouth. Jack, as he is known to all, is the first MSV president from the City of Portsmouth, and the local medical community is understandably proud of this honor accorded their city.

The son of the late Edward C. and Mattie Leggett Hollowell, Jack grew up in Deep Creek, Virginia, as the middle of five children. After graduating from Deep Creek High School, he followed his eldest sister to the College of William and Mary, where he earned a BS degree in chemistry. Although he worked his way through college (serving in the law library, the chemistry lab, and as a visitor guide), he found time for extracurricular activities and worked, among other capacities, on the college newspaper and as business manager of the school yearbook. He also participated in the College Naval Reserve program.

Jack attended the University of Virginia Medical School, graduating in the Class of 1946. After a 15-month rotating surgical internship in Charlottesville, he served two years' active duty as a medical officer in the Navy, most of which was spent aboard the destroyer tender *Grand Canyon*.

Following his discharge from the Navy, Jack moved to New York City for a three-year residency in urology at Roosevelt Hospital under chief-of-staff Dr. Simon Beisler. Jack and Dr. Beisler, who later served as president of the American Urological Association, became close friends, and after completing his residency, Jack was invited into Dr. Beisler's practice. But Jack declined, explaining he was "just a country boy" who wanted to go home to practice.

Jack served as Roosevelt's chief urology resident for a time and was instrumental in building a lounge for the medical staff with the help and resources of Nancy

Walker, a well-known Roosevelt benefactor. (Miss Walker was an aunt of President George Bush, and Jack recalls visiting the now famous Kennebunkport home familiar to television viewers today.)

While at Roosevelt, Jack met Mary Louise Akert, who was in training as an RN. Jack's wry sense of humor found a match in Mary Lou's own, and the two were married in New York City in 1953. Mary Lou, a native of Flin Flon, a small mining town in northwest Manitoba, recalls that their honeymoon was spent on the road since Jack was in transit to his new practice in Virginia (a portent of his growing life-long commitment to the practice of medicine).

Upon returning south, Jack opened a solo practice as the first urologist in Portsmouth. In the mid-sixties, together with Frank B. Clare, a neurological surgeon, he constructed a five-suite medical building opposite Portsmouth General Hospital from which he still practices today. He is on the staff at both Portsmouth General Hospital and Maryview Medical Center. An admiring colleague notes of Jack that "He has a lot of common sense, and his patients like that. And his work is consistently good."

In early 1991, Jack brought into practice with him Dr. William A. Julian, who had most recently been practicing in Peterborough, New Hampshire. (Dr. Julian, a graduate of Washington and Lee, received his MD from the University of Kentucky.)

Jack has had a long and distinguished career in the service of medicine and community. He is a former president of the Tidewater Urological Society (1968) and the Portsmouth Academy of Medicine (1969) and former president of the medical staff at Portsmouth General Hospital. He was chairman of surgery at both Portsmouth hospitals, Portsmouth General and Maryview Medical Center. He currently serves as assistant professor of urology at Eastern Virginia Medical School and was for 25 years a consultant to the United





JOHN W. HOLLOWELL, MD,  
PRESIDENT, 1991-1992, THE MEDICAL SOCIETY OF VIRGINIA

States Naval Hospital in Portsmouth.

He was Portsmouth's representative during the development of Tidewater's first HMO (Health Plan of Virginia) and had five years of service on the board of directors of the Eastern Virginia Health Systems Agency.

More recently he has served as a director of the Tidewater Regional Health Planning Council and of Tidewater Health Care (the corporate parent of both Virginia Beach and Portsmouth General Hospitals).

A tireless Portsmouth booster, Jack has chaired the Portsmouth Planning Commission and is past president and a current active member of the Rotary Club of Portsmouth. He has served on the vestry at Trinity Episcopal Church in Portsmouth, and he and his wife remain active in that congregation.

Jack's experience also includes work on the MSV Vanguard Committee, a legislative innovation of the early eighties; on the blue ribbon panel appointed in 1985 to work with the State Board of Medicine on modifications of the Board's disciplinary functions; and, in the mid-eighties, on the state task force created to study the distribution of Medicaid funds. In 1987 he was elected to the Medical Society of Virginia's Council for the 4th district after serving for five years as vice-councilor. In 1990 the House of Delegates named him President-Elect.

Jack and Mary Lou have four children, all of whom were born in Portsmouth. The eldest, Heather, is an executive with a pharmaceutical company in New York City. Mary Louise (Lou) is married to an accountant and resides in Richmond with their year-old son, John Curtis. Lesley, a primary schoolteacher, is married to a history professor at Rochester Institute of Technology. They live with their infant daughter, Mary Caroline, in Waterloo, New York. John pursues his interest in the environment with the Virginia Department of Health and lives in Wicomico Church with his wife and baby daughter, Sarah Tucker. All four of the Hollowell children vividly recall sitting in various nurses' stations as their father made hospital rounds on Sunday afternoons after church. They also recollect long waits in hospital parking lots while their father made patient visits. ("Mother entertained us playing endless games of 'I Spy with My Little Eye' to pass the time," remembers one.)

Jack and Mary Lou reside in Portsmouth, Virginia, where Jack spends what little free time he has gardening and puttering around the house. The Hollowells also enjoy occasional weekends at their beach house at Corolla on the Outer Banks. But as Mary Lou notes, "Jack is happiest when he is practicing medicine: He has little time for hobbies. His hobby is work."

## Kudos

**T**HE Medical Society of Virginia has been the recipient of double good fortune in the year 1990-1991. Dr. John Owen has served as an outstanding leader, perceptive, industrious, and gifted with sound judgment. In addition, he has had time to do his job. The MSV owes a debt of gratitude to Dean Robert Carey of the University of Virginia School of Medicine. Dr. Carey has seen fit to provide for Dr. Owen this year as a sabbatical; he thus has provided an essential commodity—free time. Dr. Owen has utilized this opportunity.

Now for the changing of the guard: Dr. John Hollowell, of Portsmouth, assumes the post as MSV President. Dr. Hollowell is professor of urology, Eastern Virginia Medical School, and has been a consultant in urology at the U.S. Naval Hospital for the past 25 years. He also has served as president of the Portsmouth Academy of Medicine. Dr. Hollowell has served on the MSV council since 1982. Obviously, our organization will remain in capable hands.

E.L.K., JR.

## To Ease Costs, Give and Take

**I**N A NATION that prides itself on providing the best medical care anywhere, it is becoming clear that the best is less and less accessible. We are an insurance-spoiled society, and health insurance is rapidly becoming no longer affordable to many. To achieve affordability, it is imperative that there be a give and take among the main players in health care.

The consumer must realize that health care is not a birthright. The poor and the rich of this country, when treated or hospitalized, are accorded comparable standards of care. This is excellent as far as medical care is concerned, but when the standard is carried to amenities such as hospitals with all private rooms equipped with color TV and private phone, then something has to give.

The physician must discuss frankly and thoroughly with the patient and/or family the cost of any proposed treatment or hospitalization. This should include disclosure of the physician's interest in any diagnostic or laboratory facility to which the patient is being referred.

To hold down costs, every hospital should allocate a minimum percentage, say 20-40% of total beds, to less expensive semiprivate or ward beds.

Insurers are now placing fee and cost restrictions on providers, but this effort is clearly "too little, too late," and a major overhaul (legislation?) of the role of





# VIRGINIA MEDICAL OBITUARY

## Memoir of Simon Russi 1911-1991

*By Alvin Cohen, MD*

Dr. Simon Russi died of cancer on May 7, 1991, at his home in Alexandria, Virginia. He was 80 years old.

A native of Rovno, Ukraine, Dr. Russi was a graduate of Karlova University in Prague and received his medical degree from Regina University in Modena, Italy. He came to the United States in 1938 and interned at St. Louis City Hospital.

He served with the Army Medical Corps in the South Pacific during World War II and subsequently was chief pathologist for 12 years at McGuire Veterans Hospital in Richmond. In 1957 Dr. Russi became chief pathologist and director of the lab at Petersburg General Hospital and served for 21 years in that capacity. During that time he served also as clinical professor of pathology and clinical pathology at Virginia Commonwealth University/Medical College of Virginia in Richmond. When he left in 1978 and moved to Alexandria, he obtained a position as clinical professor of pathology at George Washington University Medical School in Washington, DC, where he served for the next 12 years until his retirement.

Dr. Russi was a member of the College of American Pathologists, American Society of Clinical Pathologists, American Association of Pathologists, International Academy of Pathology, Virginia Society of Pathology, Society of Medical Consultants to the Armed Forces, Medical Society of Virginia, American Medical Association, Southside Virginia Medical Society, and American Association of Pathologists and Bacteriologists.

Dr. Russi is survived by his wife, Gertrude K. Russi; two daughters, Judith Russi Kirshner of Chicago and Rosemarie Russi Howe of Alexandria; and four grandchildren.

The above are the facts and figures of Dr. Russi's life in medicine. But there is much more to a remembrance of his life.

I met Simon Russi in 1957 when he accepted the position of pathologist at Petersburg General at about the same time I entered practice as an internist and director of the Nuclear Medicine Department of Southside Regional Medical Center, which was subsequently merged with Petersburg General. My relationship with Simon was therefore unique, lasting for the next 21 years and our friendship beyond that.

Simon managed the lab and his technicians with

wisdom and kindness and a gentle hand. He was respected and loved by his techs. He was respected and trusted and relied upon by his colleagues on the medical staff, by the medical community around Petersburg and later, I'm sure, by the physicians and medical students at George Washington Medical School.

Simon Russi's legacy lives in the many physicians whom he befriended and who trusted and respected him and the host of medical students and interns and residents who carry the memory of his teachings and his gentility in their hearts and in their minds. He will be remembered by all of them and most especially by the author of this memoir.

## Memoir of Weir Tucker 1913-1991

*By James A. Shield, Jr., MD*

Dr. Weir Mitchell Tucker died on February 26, 1991, in Richmond after many years of neuropsychiatric practice. He was the son of the late Beverley Randolph Tucker, MD, founder of Tucker Hospital, Richmond.

Born in Richmond in 1913, he received his medical degree from the University of Virginia School of Medicine and his training in psychiatry from the New York Institute and Hospital and the Institute of the Pennsylvania Hospital, Philadelphia, and in neurology at the Jefferson Hospital and Medical School in Philadelphia. After service in World War II in the medical corps, he returned to Richmond in the private practice of neuropsychiatry at the Tucker Hospital. At the Medical College of Virginia, he formed the newly organized Department of Neurology as its first chairman and continued his teaching association at the Medical College of Virginia for many years.

He was president of the Richmond Chapter of the Mental Hygiene Society of Virginia, which his father had helped found, and president of the board of the former Speech Center sponsored by the Junior League of Richmond. He was president of the Southern Psychiatric Association in 1972, and a former president of the Psychiatric Society of Virginia as well as the University of Virginia Medical Alumni Association and the Virginia Society of the Cincinnati. The University of Virginia named Dr. Tucker the school's outstanding medical alumnus in 1989. He was a diplomate of the American Board of Psychiatry and Neu-



rology.

Dr. Tucker organized and carried out the relocation of the Tucker Hospital to the Tucker Pavilion-Chippenham Medical Center in 1976 and was a member of the board of directors of Chippenham Medical Center for a number of years. In addition, he was president of the Tucker Psychiatric Clinic until 1982.

Dr. Tucker was a member of the Country Club of Virginia, the Commonwealth Club and St. Paul's Episcopal Church.

He is survived by his wife, Linden Crawford Tucker, and two daughters, Mrs. Stephen R. Bell of Chevy Chase, Maryland, and Dr. Pamela Tucker of Baltimore, and a sister, Mrs. Elsie Taylor of Richmond.

## Memoir of Samuel W. Budd 1915-1991

*By William S. Dingledine, MD*

Dr. Samuel Walthall Budd, who died on January 12, 1991, after a long illness, was born in Petersburg, Virginia, on July 17, 1915, and grew up in Richmond where his father was an eminent pathologist. Sam attended St. Christopher's School and received both his undergraduate and medical degrees from Yale University. After interning at the Medical College of Virginia he served in the United States Navy during World War II, at first in the Philippines and later at the Naval Academy in Annapolis. Following the war he received residency training in internal medicine at Union Memorial Hospital, Baltimore, and Johnston-Willis Hospital, Richmond. In 1948 he entered the private practice of internal medicine in Richmond and continued until his retirement in 1989.

Sam was dedicated to the care of his patients and his patients were devoted to him. Throughout his practice years he continued to make house calls when necessary for the good of his patients. He was a compassionate physician with a remarkable sense as to the needs of his patients. His ability to solve a complex diagnostic problem was matched only by his concern for the welfare of the patient. His counsel was frequently sought by his colleagues. The medical community has lost a distinguished member and his presence will be sorely missed.

Sam was on the staff of Johnston-Willis, Stuart Circle and Henrico Doctors' Hospitals and was a Clinical Associate in Medicine at the Medical College of Virginia. He was a member of the Richmond Academy of Medicine, the Medical Society of Virginia and the American Medical Association. He was certified by the American Board of Internal Medicine.

Dr. Budd is survived by his wife, Emilie Mueller Budd; three daughters, Ann F. Budd of Iowa City,

Iowa, Emilie M. Budd of Dolores, Colorado, and Helen B. Jennings of Winchester, Virginia; and a brother, George Cameron Budd of Richmond. We share with his family the loss of a friend and fellow physician.

## Memoir of John Earle Smith 1923-1990

*By Tony Constant, Jr., MD*

John Earle Smith, MD, was my friend and partner for over 25 years. He received his medical degree from the Medical College of Virginia in 1950, and practiced in Richmond until his retirement in 1989. He was medical director of the Masonic Home from 1955 until his death December 29, 1990. He was an emergency physician from 1963 until 1989 and was in family practice for ten years before that. He served in the United States Army during the Korean campaign.

Dr. Smith was a member of almost all the professional societies available to a physician. He was devoted to his profession and to his patients. His memory will be cherished by his family, friends and patients. I certainly will miss him.

He is survived by his wife, Barbara, three daughters and two sons.

• **William Eugene Apperson, MD**, retired Richmond pulmonologist; University of Virginia School of Medicine, 1935; age 81; died September 7, 1991.

• **L. James Buis, MD**, Richmond pulmonologist; University of Nebraska College of Medicine, 1937; age 78; died September 4, 1991.

• **William McCoy Eagles, MD**, retired Richmond neurosurgeon; Duke University School of Medicine, 1943; age 71; died September 12, 1991.

• **David C. Forrest, MD**, professor at the Medical College of Virginia and retired Richmond obstetrician/gynecologist; Medical College of Virginia, 1950; age 73; died November 19, 1991.

• **Henry Charlton Graybeal, MD**, Christiansburg general practitioner; Johns Hopkins University School of Medicine, 1948; age 67; died August 29, 1991.

• **Gershon J. Levin, MD**, retired Norfolk surgeon; University of Virginia School of Medicine, 1933; age 84; died August 22, 1991.

• **Joseph R. Macys, MD**, Richmond orthopedic surgeon; Ohio State University College of Medicine,

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**Contraindications:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests:** False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions:**—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients:**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic:**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular:**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS:**—Rare cases of reversible mental confusion have been reported.

**Endocrine:**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic:**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental:**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity:**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other:**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.


**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

References

1. Data on file, Lilly Research Laboratories.
2. Scand J Gastroenterol. 1987;22(suppl 136):61-70.
3. Scand J Gastroenterol. 1987;22(suppl 136):47-55.
4. Am J Gastroenterol. 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request



**Eli Lilly and Company**  
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1965; age 52; died November 10, 1991 while awaiting a heart transplant.

• **Richard Campbell Manson, MD**, Richmond; Medical College of Virginia, 1934; age 83; died November 29, 1991. He was a past president of the Richmond Academy of Medicine and the Virginia Dermatological Society.

• **Samuel Marshall McDaniel, MD**, retired Norfolk thoracic surgeon; University of Virginia School of Medicine, 1941; age 74; died August 18, 1991.


• **Ernest S. Roberts, MD**, retired Hampton general surgeon; Rush Medical College, Chicago, 1928; age 93; died January 8, 1991.

• **John Lewis Smoot, MD**, retired Fredericksburg general surgeon; Johns Hopkins University Medical School, 1937; age 80; died November 10, 1991.

• **George Henri van Driem, MD**, Toano general practitioner; Medische Faculteit Rijksuniversiteit Te Leiden, Netherlands, 1953; age 67; died November 4, 1991. Dr. van Driem was a past president of the Williamsburg-James City County Medical Society.

U.S. Post Service STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION Required by 39 U.S.C. 3685			
1A. Title of Publication		1B. PUBLICATION NO.	
Virginia Medical Quarterly		1 0 5 2 4 2 3 1	
3. Frequency of Issue		2. Date of Filing	
Quarterly		9/18/91	
4. Complete Mailing Address of Known Office of Publication (Street, City, County, State and ZIP+4 Code) (Not printer)		3B. Annual Subscription Price	
4205 Dover Road, Richmond, Virginia 23221		\$24.00	
5. Complete Mailing Address of the Headquarters or General Business Office of the Publisher (Not printer)			
4205 Dover Road, Richmond, Virginia 23221			
6. Full Names and Complete Mailing Addresses of Publisher, Editor and Managing Editor (This form MUST NOT be blank)			
Publisher (Name and Complete Mailing Address)			
The Medical Society of Virginia, 4205 Dover Road, Richmond, Virginia 23221			
Editor (Name and Complete Mailing Address)			
Edwin L. Kendig, Jr., MD, 4205 Dover Road, Richmond, Virginia 23221			
Managing Editor (Name and Complete Mailing Address)			
Ann Gray, Virginia Medical Quarterly, 4205 Dover Road, Richmond VA 23221			
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10. Extent and Nature of Circulation (Give numbers on separate lines)		Average No. Copies Each Issue During Preceding 12 Months	
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B. Paid and/or Requested Circulation 1. Sales through dealers and carriers, street vendors and counter sales		0	
2. Mail Subscriptions (Paid and/or requested)		5,683	
C. Total Paid and/or Requested Circulation (Sum of B-1 and B-2)		5,683	
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies		1,212	
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# MEETINGS

**February 28-March 1**

**Annual Meeting of the Virginia Chapter, American Academy of Pediatrics and the Virginia Pediatric Society**, *Williamsburg*. Marlene Hardimon, 804-643-8130.

**March 2-5**

**Alton D. Brashear Postgraduate Course in Head and Neck Anatomy** (Medical College of Virginia/VCU), *Richmond*. 40 credit hrs. Fee \$400. Dr. Hugo R. Seibel, 804-786-9624.

**March 13-15**

**Systems Review of Geriatric Medicine** (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

**March 28-April 1**

**Comprehensive Review of Clinical Obstetrics and Gynecology** (Georgetown University Medical Center), *Washington, DC*. CME Office, 202-687-8735.

**April 1**

**39th Annual Clinical Conference** (Obici Hospital), *Suffolk*. George J. Carroll, MD, 804-934-4000.

**April 3-5**

**7th Annual Review Course in Reproductive Endocrinology and Assisted Reproduction** (Eastern Virginia Medical School), *Pentagon City, Virginia*. Jeanette Schmitz, 804-446-6140.

**April 3-5**

**12th Annual Ophthalmology Conference** (Medical College of Virginia/VCU), *Williamsburg*. CME Office, 804-786-0494.

**April 6-9**

**Mammographic Techniques and Interpretation** (University of Virginia School of Medicine), *Southampton, Bermuda*. 20 credit hrs. Fee \$475. R. L. Boswell, 804-924-9387.

**April 10-12**

**Scientific Meeting of the Virginia Chapter, American College of Physicians**, Omni Hotel, *Norfolk*. Oscar E. Edwards, MD, Governor, 804-622-4204.

**April 10-11**

**31st Annual Swineford Allergy Conference** (University of Virginia School of Medicine) *Charlottesville*. 8.5 credit hrs. Fee \$100. Mattie Hackney, 804-924-2227.

**April 10-12**

**Emergency Medicine Stress and Wellness** (Virginia Chapter, American College of Emergency Physicians), *Williamsburg*. 16 credit hrs. Gwen E. Messler Harry, 804-966-5966.

**April 10-12**

**14th Annual Emergency Medicine for the Primary Care**

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**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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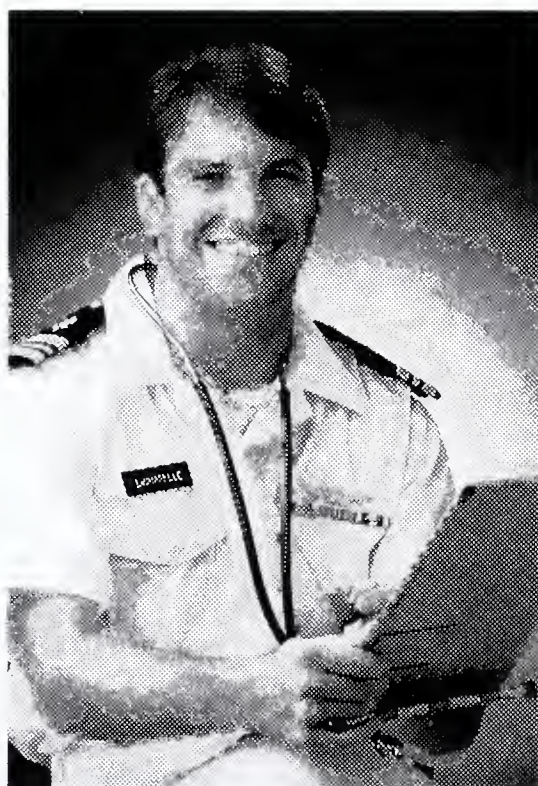
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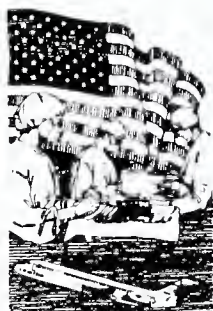
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The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdose. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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Consult the package literature for prescribing information.  
**Indication:** Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A  $\beta$ -hemolytic streptococci).

**Contraindication:** Known allergy to cephalosporins.

**Warnings:** CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

#### Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

#### Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,


and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

#### Abnormalities in laboratory results of uncertain etiology.

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (glucose enzymatic test strip, Lilly).

PA 8791 AMP [021490LR]  
Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

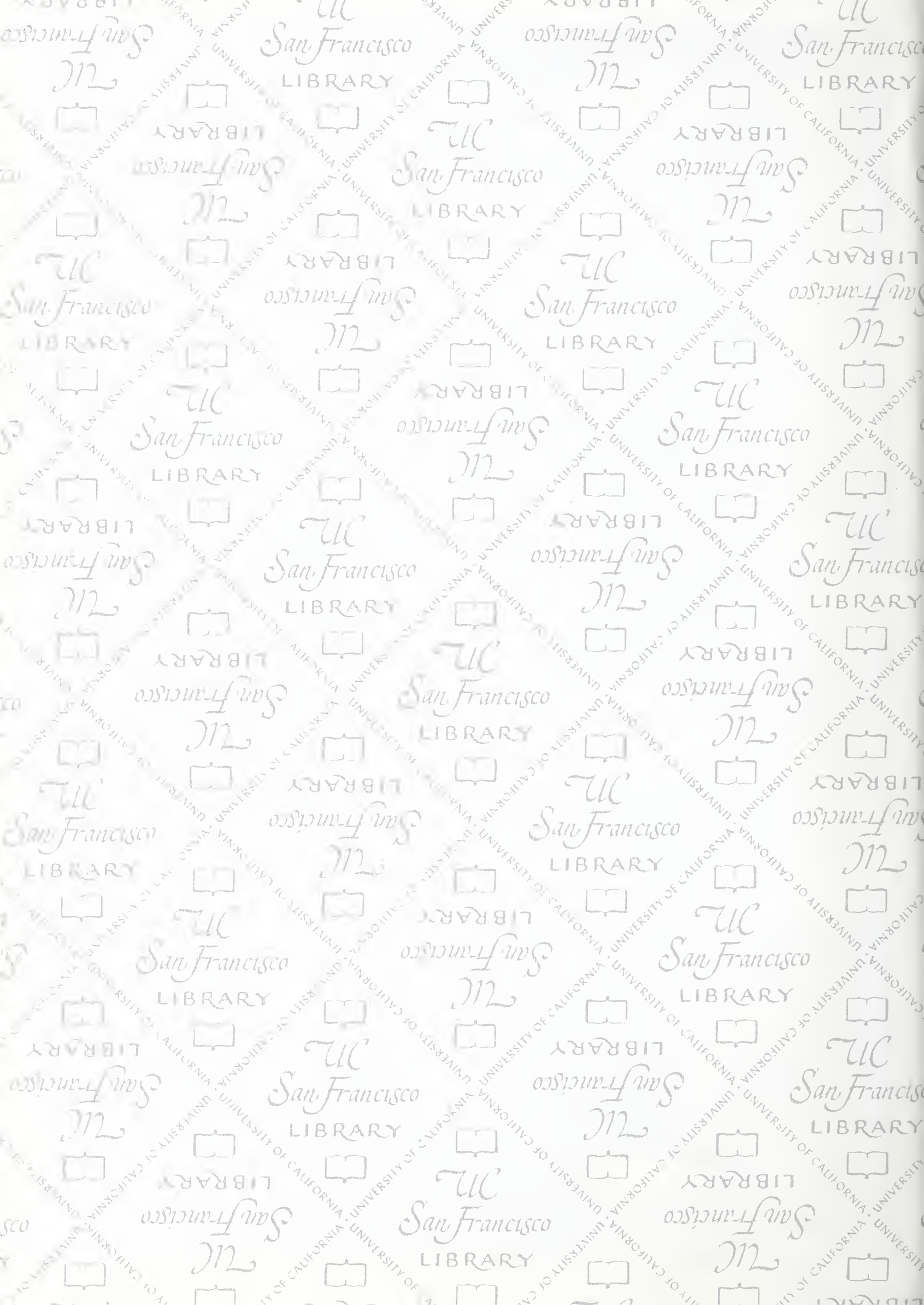
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